

DNP Verification of Precepted Clinical Hours Form

Office of Student Affairs
 UNC Chapel Hill School of Nursing
 Carrington Hall CB 7460
 Chapel Hill, NC 27599-7460
 SON_gradnursing@unc.edu

Applicant Information *(The applicant should complete this section and then send to the School of Nursing Official for verification.)*

Student Name (Last, First, MI): _____

Other Names/Spellings: _____

Type of Graduate Degree (e.g. MSN, MS) or Post-Master's Certificate: _____

Name of Institution From Which Degree Was Obtained: _____

Population or Specialty Area (e.g. FNP, Administration): _____

Month/Year Graduated: _____

To Be Completed by School of Nursing Official (Program Director or Dean)

The above applicant for admission to UNC-Chapel Hill School of Nursing Doctor of Nursing Practice program. Please verify the total number of precepted (supervised) clinical hours in the applicant's MSN or post-master's program.

University/College Name: _____

School Mailing Address: _____

Nursing Official and Title (please print): _____

Email Address: _____ Phone Number: _____

I verify that _____ (applicant above) has completed _____ precepted/supervised clinical hours in their advanced nursing preparation as _____ (e.g.) FNP, Administration).

Name and Title of School Official (please print): _____

School Official Signature: _____ **Date:** _____