CAROLINA NURSING

Verification of Precepted Clinical Hours from Prior MSN Program 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 precepeted (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): ______________________________

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School Official Signature: ______________________________ **Date:** ______________