Doctor of Nursing Practice Program
Quinnipiac University School of Nursing

Verification of Master's Program Clinical and Practice Hours

- **Instructions:**
  The DNP post-master's applicant should forward this form to the director of the master's program at the university that conferred his/her master's degree. Once the form is completed by the program director, it should be returned to:

  QUINNIPIAC UNIVERSITY ONLINE ADMISSIONS
  275 Mount Carmel Avenue, OF-QUO
  Hamden, CT 06518-1908
  Email: quonlineadmissions@quinnipiac.edu
  Fax: 203-582-3352

Student Name (Print or type) _____
First Middle Initial Last

Date of Birth: _____

The Program Director should provide the following information:

1. Name of University:_____

   Program Name: _____

   University Address: _____

   University Telephone Number: _____

2. Type of Degree Received: _____ Master's of Science in Nursing
   _____ Post- Masters Certificate
   _____ Other (please specify) _____
3. Area of Concentration: _____
4. Date of Program Completion: _____
5. Total number of clinical/practice/fieldwork hours in the program: _____
6. Was a thesis completed for this program? Yes ☐ No ☐

   If yes:
   Sole authorship? _____

   Joint authorship? _____

Program Director (print name) _____

Program Director (signature) _____

Date: _____