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: _________________________________