Quinnipiac
School of Nursing

Doctor of Nursing Practice Program
Verification of Master's Program Clinical and Practice Hours

Instructions for the DNP post-master's applicant: Please forward this form to the director of the master's program at the university that conferred your master's degree. Once the form is completed, it must be returned to you and uploaded to your application.

_____ _____ _____

Student's first name Middle initial Last name

_____

Date of birth

Program director please provide the following information:

1. Name of university: _____

   Program name: _____

   University address: _____

   University telephone number: _____

2. Type of degree received: ☐ Master of Science in Nursing ☐ Post-Master's 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 (enter name) _____

Program director (signature) _____

Date: _____

Return completed form to program applicant.