Western Kentucky University
School of Nursing
Doctor of Nursing Practice
Verification of MSN Clinical and Practice Hours

To the applicant: WKU requires verification of your graduate MSN or post-MSN clinical hours. Please insert your name and social security number on this form and send it to the Program Director of the MSN program you attended. The program director should mail this completed form **back to you** for your application submission.

Name_____
FIRST MIDDLE MAIDEN LAST

University_____ Phone Number_____

Program Title_____

University Address_____
STREET ADDRESS

Type of Degree Received: ○ Master of Science in Nursing Program
○ Post-Master's Certificate Program

Area of Concentration: _____

Date of Program Completion_____ Total Number of Clinical Practice Hours in Program_____

Program Director Verification

Your signature on this form attests that the above named individual has completed the program indicated on this document.

Printed Director Name_____

Director Signature_____ Date_____