COLORADO MESA UNIVERSITY

Doctor of Nurse Practice Program

Validation of Supervised Clinical Practice Hours

Instructions to Students: Please forward this form to the Program Director of your MSN program in order to validate your supervised clinical practice hours in that program. If your program no longer exists, please forward this form to the Graduate Coordinator, Associate Dean for Graduate Programs, or comparable administrator of your alma mater. They should be able to access your student file and obtain this information.

Student's Name:_____ CMU ID:_____

Signature of Student:_____ Date:_____

1. **The individual named above graduate from:**

_____
Name of University

_____
Program Name

_____
Program Address

_____
Program Phone Number

2. **Date Degree Conferred:**_____

3. **Number of supervised clinical practice hours completed in this program:**_____

4. **Program director/chair signature:** Your signature on this form attests that the above mentioned individual completed the MSN program and clinical hours indicated above.

Program Director/Chair (Print Name):_____

Signature:_____ Date:_____

Developed: 6/5/13