GARDNER-WEBB UNIVERSITY
GRADUATE ADMISSIONS

Verification of Practicum Hours in MSN Program/Post-Master's Certificate Program

Applicant, please allow sufficient time for the program director to complete and return this form to you for inclusion with your application. The program director should complete items 1-6 and return the form to the applicant to include with an application.

(Please print legibly or type)

Applicant Information

Name ____
Last First Middle Preferred

Social Security Number ____

1. Name of University ____

 Program Name ____

 University Address ____
 Street/Box Number City State Zip

 University Telephone ____

2. Type of Degree Received
 - ❑ Master of Science in Nursing
 - ❑ Post-Master's Certificate Program

3. Date of Program Completion ____

4. Area of Concentration ____

5. Total Number of Clinical Practice Hours in Program ____________________
 Clock Hours

6. Verified by

 Program Director (Print Name) ____

 Signature ____

 or

 Attach Syllabus and Official Catalog Description of Course

 Registrar's Printed Name____

 Signature ____

 Date ____