

**Preceptor Verified Clinical Hours for**

**Post-Master’s DNP Applicants**

Applicant: Please complete Part A of this form before sending to the Program Director or Program Coordinator where you earned your Master’s of Science in Nursing degree.

**Part A: Completed by the Applicant**

Student’s Full Name:

Name on Transcript if different then above:

ID Number or Date of Birth:

**Part B: Completed by the Program Director or Program Coordinator**

University Name:

Department:       School:

Address:

Name:       Title:

Telephone Number:       Email:

Degree Awarded:

Specialization:       Degree Awarded Date:

Total number of preceptor verified field experience hours the above named individual completed through the graduate nursing program:

I acknowledge that the above number of preceptor verified field experience hours have been completed by the individual requesting this form while he/she was a student at our institution enrolled in the graduate nursing program.

Signature: Date:

Please return to: Northern Illinois University, School of Nursing, DeKalb IL 60115

Phone 815.753.2163 l Fax 815.753.0814 l Email to: slyons2@niu.edu