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