**University of Michigan School of Nursing**
**Doctor of Nursing Practice (DNP) Program**
**400 North Ingalls, Ste 1160**
**Ann Arbor, MI 48109**

Validation of Supervised Clinical Practice Hours

Please forward this form to the Program Director or Academic Advisor of your completed masters program to validate your supervised clinical practice hours in that program. If your program no longer exists, please forward this form to the Associate Dean for Graduate Programs or comparable administrator of your alma mater for validation.

**To be completed by Student:**

**Student's Name:** ____________________________________________

**Alma Mater Student ID or Social Security Number:**_________________________

**Name of University/School where Graduate studies were completed:**

_____________________________________________________

**Program Name/Concentration:**____________________________________

**Complete mailing address of University/School:**

_____________________________________________________

_____________________________________________________

**Signature of Student:** ______________________________ **Date:**_________

**The following information needs to be completed by an approved (see above) administrator from the above listed institution:**

Please complete the below information based on the student file of the above listed student.

**Date of Graduation of Student (MM/DD/YYYY):**_____________________________

**Degree Conferred of Student:**__________________________________________

**Number of Supervised clinical practice hours completed by the student:**________________

**Name of Authorized Administrator (Print):**_________________________________

**Title:**____________________________________________________________

**Signature:**_________________________________________________________

**Date:**__________________