

# Verification of Post-Baccalaureate Clinical and Practice Hours



Ida V. Moffett School of Nursing  
Samford University

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 \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Last First Middle Preferred

1. Name of University \_\_\_\_\_

Program Name \_\_\_\_\_

University Address \_\_\_\_\_  
Street/Box Number City State Zip

University Telephone \_\_\_\_\_

## 2. Type of Degree Received

- Master's of Science in Nursing Program  
 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. Your signature on this form attests that the above named individual has completed the program indicated on this document.

Program Director (Print Name) \_\_\_\_\_

Program Director Signature \_\_\_\_\_ Date \_\_\_\_\_

This form may be duplicated as needed.