

Validation of Advanced Practice Nursing Clinical Hours and APN Core

INSTRUCTIONS

The individual listed below has applied for admission to the Michigan State University College of Nursing Doctor of Nursing Practice and/or Post-Graduate Certificate program(s). As Associate Dean or Program Director of the applicant's MSN or Post Masters Program, please verify the information below, documenting clinical hours and APN Core Coursework completed in the Program. The student has authorized release of this information for the purposes of application only. **Please return this form to the applicant so that it may be uploaded to the application. You may also send it to the College of Nursing Office of Student Affairs via Email: CON.Admissions@msu.edu or Fax: (517) 432-8251.** All Forms must be received by the application deadline.

STUDENT INFORMATION & AUTHORIZATION TO RELEASE INFORMATION: - Applicant Completes

Applicant Last Name	First Name	MI
Street Address		
City	State	Zip
Student Email		

Authorization for Release of Information:

I authorize the requested information to be released to Michigan State University College of Nursing for the purposes of application to the Doctorate of Nursing Practice Program.

Signature	Printed Name	Date
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INSTITUTION INFORMATION: - Institution Completes

NAME OF UNIVERSITY	CITY	STATE
PHONE NUMBER	EMAIL ADDRESS	
TYPE OF DEGREE	CONCENTRATION/SPECIALTY	DATE CONFERRED
DESIGNATE THE ORGANIZATION(S) THAT ACCREDITS YOUR PROGRAM: <input type="checkbox"/> CCNE <input type="checkbox"/> NLNAC <input type="checkbox"/> COA		
WAS THE PROGRAM ACCREDITED AT THE TIME THE STUDENT ATTENDED AND GRADUATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
(IF NO, PLEASE EXPLAIN) _____		

TOTAL FACULTY SUPERVISED CLINICAL HOURS: _____

ADVANCED PRACTICE CORE: Please check the appropriate boxes to indicate that the following three separate, comprehensive courses were included in the student's program of study and the content was across the lifespan.

Advanced Pathophysiology Advanced Pharmacology Advanced Physical Assessment

NAME OF INDIVIDUAL VERIFYING INFORMATION (INCLUDE CREDENTIALS)	TITLE
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SIGNATURE	DATE	EMAIL ADDRESS
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