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**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 Program. 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.Nurse@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**

**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: ❒ CCNE ❒ NLNAC ❒ COA**

**WAS THE PROGRAM ACCREDITED AT THE TIME THE STUDENT ATTENDED AND GRADUATED? ❒ YES ❒ NO**

**(IF NO, PLEASE EXPLAIN)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TOTAL FACULTY SUPERVISED CLINICAL HOURS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADVANCED PRACTICE CORE: Please check the appropriate boxes to indicate that the following courses were included in the student’s program of study. ❒ Advanced Pathophysiology ❒ Advanced Pharmacology ❒ Physical Assessment**

**NAME OF INDVIDUAL VERIFYING INFORMATION (INCLUDE CREDENTIALS) TITLE**

**SIGNATURE DATE EMAIL ADDRESS**