Appendix A

UTHealth The University of Texas Health Science Center at Houston | Cizik School of Nursing

Doctor of Nursing Practice Program

Supervised Clinical Practice Verification Form in Master's Degree Program
(*Please type all Information***)**

Student's name: _____

Directions: I am requesting your assistance in verifying the number of supervised clinical practice hours that the student who is listed above has had within her/his master's degree program. Supervised clinical practice hours are defined as:

a planned clinical practice experience as part of an academic course which is overseen by the course faculty member during which time the student is engaged in direct patient care. The student may be working with an on-site preceptor, but the overall experience is planned and supervised by the academic course faculty.

Please provide the following information:

Name of School/University _____

Name of program (e.g. MSN, INF)

This section below must be completed by an authorized administrator, not the student to be <u>ACCEPTED.</u>

Course #	Course Name	# Supervised Practice Hours	Semester and Year

Total number of supervised clinical practice hours in master's program _____

Administrator Printed Name: _____

Administrator Title: _____

Address: _____

Signature: _____

Please return to: Ms. Tarsha S. Young
Program Manager for the **D**octor of **N**ursing **P**ractice **P**rogram
6901 Bertner Avenue| Room 649| Houston, Texas 77030
Email: Tarsha.S.Young@uth.tmc.edu

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Assessment of Post-BSN Supervised Clinical/Practice Hours

If a student does not have documented evidence of a minimum of 520 post-baccalaureate supervised clinical/practice hours in their nursing master's and/or post-graduate nursing program, the student will be required to complete additional hours during the Cizik School of Nursing DNP program to attain the deficit hours and meet the requirements for the DNP degree and graduation.

Student: Click or tap here to enter text.

Advisor: Click or tap here to enter text.

Name/Location of Nursing Program	Course No. & Title	No. of Supervised Clinical Hours	Transcript and/or Syllabus Reviewed

Plan to Complete Additional Required Hours

Number of Additional Supervised Clinical Hours Required _____

Semester Independent Study Course(s) Planned	Semester Independent Study Course(s) Completed	Number of Clinical Hours Earned

I have reviewed the information above and verified that it is accurate.

Student Signature:_____Date:_____

Advisor:_____Date: _____