LSU Health NEW ORLEANS
School of Nursing

VERIFICATION OF PRACTICUM HOURS

Student Name: _____
Last **First**

PROGRAM DIRECTOR: Please complete Items 1-6 and return this form to the student.

1. **Name of University**:_____

   Program Name: _____

2. **Type of Degree Conferred/Awarded:**
   - ☐ Master of Nursing Degree
   - ☐ Master of Science in Nursing Degree
   - ☐ Other Master's Degree – Please specify _____
   - ☐ Post-Master's Certificate Program

3. **Area of Concentration**:
   - ☐ Nurse Practitioner (specify what type) _____
   - ☐ Nurse Anesthesia
   - ☐ Clinical Nurse Specialist (specify what type) _____
   - ☐ Nursing Administration
   - ☐ Nurse Midwife
   - ☐ Nursing Educator and/or Nursing Education
   - ☐ Other

4. **Date of Program Completion**: _____

5. **Total Number of Supervised Practicum 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 Electronic Signature:

Upon completion, please return this form to the student or LSU Health Sciences Center School of Nursing Office of Student Affairs: nsstuaffairs@lsuhsc.edu