LSU Health NEW ORLEANS School of Nursing

VERIFICATION OF GRADUATE PRACTICUM HOURS

(Please print or type)

Name: _____ **Student ID**: _____

Last **First** **MI**

APPLICANT: Please complete Items 1-4 and send to the Program Director of the program you attended to complete.

PROGRAM DIRECTOR: Please complete Items 5 and 6 and return this form to the student or fax it to LSUHSC SON Student Affairs at 504-568-5711.

1. **Name of University**:_____

   Program Name: _____

   University Address:

   _____ _____

   Street/Box Number **City** **State** **Zip**

   University Telephone:

   _____

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 Administrating
   - ___Nurse Midwife
   - ____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 Signature:_____**Date**_____

Upon completion, please return this form to the student or to:

Stamp with School Seal