UNIVERSITY OF CENTRAL ARKANSAS
Department of Nursing

VERIFICATION OF CLINICAL PRACTICE

PART I: To be completed by Applicant

Applicant's Name _____

Describe your nursing care of clients within the past 5 years by addressing the following:

Name and type of agency _____

Address of agency _____

If agency was an acute care agency or hospital, describe focus of unit

_____

Types of clients: _____

Length of time employed _____ Dates of employment: _____

_____

Part II: To be completed by an immediate supervisor:

Name (Print) _____

Your position with the agency _____

Your relationship with the applicant _____

In the space below please address the patient/client population that the above graduate school applicant has cared for within your agency or institution.

_____
_____
_____
_____

I hereby certify that the above description of clinical practice of the above applicant is correct.

Signature: _____

Business Address: _____

Business Telephone: _____