



POST MASTER'S CERTIFICATE APPROVAL FORM

FOR OFFICE USE

DIRECTIONS

- 1) Student completes **Student Information** portion.
- 2) **Make an appointment** for "End of Program Survey." Call Vevlyn Rogers at (312) 942-3168.
- 3) **Circulate for authorized signatures.** Certificate will be mailed only **after** completed form is received by the Office of the Registrar.

STUDENT INFORMATION

Rush Student ID#

LAST Name _____

FIRST Name _____

Social Security # _____

Address _____

City _____

State _____ Zip _____

Home phone _____ Work _____

How should your name appear on the certificate? (no degree abbreviations):

Do you plan to earn another degree/certificate at Rush?

No Yes. If Yes, what degree/certificate? _____

What quarter and year will you start? _____

List other degrees and year earned at Rush:

1 _____ 2 _____ 3 _____

Student's Signature Date

Below indicate your Post Master's Specialty:

Check only ONE specialty only. If writing in specialty title please use **correct, approved** specialty title ONLY. (Do **not** use colloquial terms or titles)

- | | |
|--|--|
| <input type="checkbox"/> ACNP Acute Care Nurse Practitioner | <input type="checkbox"/> PHCS Community/Public Health CNS |
| <input type="checkbox"/> PANP Acute/Chronic Care Pediatric NP | <input type="checkbox"/> CCCS Critical Care Clinical Nurse Spec. |
| <input type="checkbox"/> ANP Adult Nurse Practitioner | <input type="checkbox"/> GRCS Gerontological Clinical Nurse Spec. |
| <input type="checkbox"/> FNP Family Nurse Practitioner | <input type="checkbox"/> MSCS Medical-Surgical Clinical Nurse Spec. |
| <input type="checkbox"/> GNP Gerontological Nurse Practitioner | <input type="checkbox"/> PDCS Pediatric Clinical Nurse Specialist |
| <input type="checkbox"/> NNP Neonatal Nurse Practitioner | <input type="checkbox"/> PCSA Psychiatric/Mental Health CNS-Adult |
| <input type="checkbox"/> PNP Pediatric Nurse Practitioner | <input type="checkbox"/> PCSC Psychiatric/Mental Health CNS-Child |
| <input type="checkbox"/> PNPA Psychiatric/Mental Health NP-Adult | |
| <input type="checkbox"/> PNPF Psychiatric/Mental Health NP-Family | <input type="checkbox"/> Other _____ |

SIGNATURES

Obtain signatures in **EXACT** order listed.

1 - End of Program Survey

Survey was completed on _____

Authorized Signature: *Vevlyn Rogers*

2 - Advisor/Associate Chair

Name of Student)

has successfully completed the program of study for
(see list below for correct specialty title)

_____ option at the following level:

Post Master of Science in Nursing Post Doctor of Nursing

Total Didactic hours completed _____ **Quarter hours** equivalent
to _____ **Clock hours.**

Total Clinical Practicum Hours Completed _____

Advisor's Signature Date

Assoc. Chair's Signature Date

3 - Office of the Dean

Associate Dean, *Lisa Rosenberg, Ph.D., R.N.* Date

4 - Library Library obligations checked. (All students)

Authorized Signature Date

5 - Office of Financial Aid

Authorized Signature Date

5 - Loan Collection Coordinator

Authorized Signature Date

6 - Bursar

Authorized Signature Date

7 - Registrar

Authorized Signature Date

OFFICE USE

cc: Advisor _____
 Associate Chairperson _____
 Coordinator of Informatics _____ Entered in Database
 Student _____
 Student file _____
 Office of the Registrar _____ Distributed Copies