



POST MASTER'S CERTIFICATE APPROVAL FORM

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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 and all University obligations have been met.

STUDENT INFORMATION

RUConnected ID#

LAST Name _____

FIRST Name _____

Address _____

City _____

State _____ Zip _____

Primary Phone _____

Secondary Phone _____

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

Indicate **Quarter & Year** in which you will complete certificate requirements:

- FALL (Dec) WINTER (March)
 SPRING (June) SUMMER (August) YEAR: **200** _____

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 CNS |
| <input type="checkbox"/> ANP Adult NP | <input type="checkbox"/> GRCS Gerontological CNS |
| <input type="checkbox"/> FNP Family NP | <input type="checkbox"/> MSCS Medical-Surgical CNS |
| <input type="checkbox"/> GNP Gerontological NP | <input type="checkbox"/> PDCS Pediatric CNS |
| <input type="checkbox"/> AGNP Adult/Gerontological NP | <input type="checkbox"/> PCSA Psychiatric/Mental Health Adult CNS |
| <input type="checkbox"/> NNP Neonatal NP | <input type="checkbox"/> PCSC Psychiatric/Mental Health Child CNS |
| <input type="checkbox"/> PNP Pediatric NP | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> PNPA Psychiatric/Mental Health Adult NP | |
| <input type="checkbox"/> PNPF Psychiatric/Mental Health Family NP | |

SIGNATURES

Obtain signatures in **EXACT** order listed.

1 - End of Program Survey

Survey was completed on _____

Authorized Signature: *Vevlyn Rogers*

2 - Advisor/Specialty Coordinator

Total Didactic hours completed _____

Quarter hours equivalent to _____ Clock hours.

Total Clinical Practicum Hours Completed _____

Advisor's Signature _____ Date _____

Specialty Coordinator's Signature _____ Date _____

3 - Office of the Dean

Associate Dean (or authorized signature) _____ 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: ID Received? Cleared through Parking Garage?

Authorized Signature _____ Date _____