POST MASTER'S
CERTIFICATE APPROVAL FORM

FOR OFFICE USE

DIRECTIONS

1) Student completes **Student Information** portion.
2) **End of Program Survey.** You will receive two emails with links to complete Contact Information and End of Program surveys. Your Program Assistant will collect the form and sign upon completion of surveys.
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

Student ID# 00 ___ ___ ___ ___ ___

LAST Name_____

FIRST Name _____

Address _____

City_____

State _____ Zip _____

Primary Phone_____

Secondary Phone_____

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

_____

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

☐ FALL (Dec)
☐ SPRING (April) ☐ SUMMER (August) YEAR: **20**____

_____
Student's Signature Date

Below indicate your Post Master's Major:

Check only ONE major only. (If you do not see your major listed please speak with the Office of the Registrar before submitting this form.)

- ☐ Acute Care NP (ACNP)
- ☐ Acute/Chronic Care Pediatric NP (ACPNP)
- ☐ Adult NP (ANP)
- ☐ Adult NP/Gero NP (ANPGNP)
- ☐ Adult Health CNS (ACNS)
- ☐ Adult Health CNS/Gero CNS (ACNSGCNS)
- ☐ Advanced Public Health Nursing (APHN)
- ☐ Anestheisa
- ☐ Community/Public Health CNS (CPHNCNS)
- ☐ Critical Care CNS (CCCNS)
- ☐ Family NP (FNP)
- ☐ Gerontological CNS (GCNS)
- ☐ Gerontological NP (GNP)
- ☐ Neonatal NP (NNP)
- ☐ Pediatric CNS (PCNS)
- ☐ Pediatric NP (PNP)
- ☐ Psychiatric/Mental Hlth Adult CNS (PMHACNS)
- ☐ Psychiatric/Mental Health Adult NP (PMHANP)
- ☐ Psychiatric/Mental Hlth Child CNS (PMHCCNS)
- ☐ Psychiatric/Mental Health Family NP (PMHFNP)

SIGNATURES **Obtain signatures in EXACT order listed.**

1 - End of Program Survey

Survey was completed on _____

_____
Authorized Signature: *Program Assistant*

2 - Advisor/Specialty Coordinator

Total Didactic hours completed _____

Semester hours equivalent to _____ **Clock hours**.

Total Clinical Practicum Hours Completed _____

_____
Advisor's Signature Date

_____
Specialty Coordinator's Signature Date

Note: Due to the College of Nursing Academic Calendar Change: 1 quarter hour is equivalent to .67 semester hours

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