UNIVERSITY OF WASHINGTON
SCHOOL OF NURSING
Academic Services Office

VERIFICATION OF MASTER'S DEGREE COMPLETED

(Please type or print legibly in ink)

_____, candidate for the degree of
(Same as name on Application for Degree)

Master of _____ has successfully completed all requirements for the
(Nursing or Science)

_____ focal area, **as well as** a ☐ Thesis ☐ Master's Project entitled:

_____

_____

Focal Area Advisor: _____ Date: _____
(Advisor's Signature)

Committee Members: _____, _____, _____

Date Final Examination was completed: _____

Date Thesis was submitted to The Graduate School (if applicable): _____

***Supervisory Committee Chair*:** _____ Date: _____
(Chair's Signature)

Permanent Address: _____

_____

Anticipated employment: _____
(Institution or Agency)

City and State: _____

Position (teaching, clinical specialist, NP, leadership, etc.), if known at completion:

_____

Student: _____ **Date:** _____
(Student Signature)

Note: This form does not indicate completion of a Graduate Certificate Program.

Academic Services Use Only elw 2/07

Qtrs in Program: _____ Elapsed Time: _____ FT/PT: _____ **Final GPA:** _____
Credit Hours: Total _____ Nursing: _____ Non-Nursing: _____ Project or Thesis: _____