UNIVERSITY OF WASHINGTON
School of Nursing
Academic Services Office

VERIFICATION OF POST-MASTERS WORK COMPLETED

(Please type or print legibly in ink)

_____, has
(Name as it appears in student records)

successfully completed Post-Master's coursework in the area of:

_____
(Focal Area or Name of Program)

Final Coursework was completed during _____
(Quarter, Year)

Advisor: _____

Advisor: _____ Date: _____
(Signature)

Permanent Address: _____

_____

Anticipated employment: _____
(Institution or Agency)

City and State: _____

Describe positions: teaching, clinical specialist, NP, leadership. If known at completion, indicate: _____

Student: _____
(Signature)

Date: _____

Note: This form does not indicate completion of a Graduate Certificate or Master's 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: _____