TROY UNIVERSITY
COLLEGE OF HEALTH AND HUMAN SERVICES
DOCTOR OF NURSING PRACTICE PROGRAM
INFORMATION SHEET

NAME: _____S.S.#_____-_____-_____
First MI Last

MAILING ADDRESS: _____
Street City State Zip Code

TELEPHONE NUMBER: WORK (_____)_____ HOME (____)_____

Post Baccalaureate only: PROPOSED DNP CLINICAL MAJOR (SELECT ONE): _____ ADULT HEALTH (CNS)

_____MATERNAL INFANT (CNS) _____ FAMILY NURSE PRACTITIONER

Post MSN only: MSN clinical focus: CNS _____ FNP _____ Other _____

SELECT ONE: _____ FULL-TIME STUDY _____ PART-TIME STUDY

TOTAL TIME OF CLINICAL EXPERIENCE AS A REGISTERED NURSE: _____ YEARS

MOST RECENT WORK EXPERIENCE:_____
INSTITUTION

_____
POSITION

_____
DATES

REQUEST FOR PHYSICAL ASSESSMENT EVALUATION

I COMPLETED THE FOLLOWING UNDERGRADUATE OR GRADUATE COURSE IN PHYSICAL ASSESSMENT:
COURSE NUMBER AND TITLE: _____

PLACE TAKEN: _____

CREDIT HOURS OF COURSE: _____WHEN TAKEN: _____

OR

MY UNDERGRADUATE PHYSICAL ASSESSMENT WAS INTEGRATED INTO MY BSN PROGRAM OF STUDIES AT:
_____ UNIVERSITY/COLLEGE

TEXT(S) AND AUTHOR(S) USED IN STUDY: _____

HOW WERE COMPETENCIES EVALUATED?
_____

_____

_____

_____ _____
SIGNATURE DATE