SCHOOL OF NURSING

WILLIAM PATERSON UNIVERSITY

GRADUATE PROGRAM IN NURSING ● UNIVERSITY HALL 302
300 POMPTON ROAD ● WAYNE, NEW JERSEY 07470-2103
973.720.3511

Doctor of Nursing Program

DNP Practicum Employer Acknowledgment

DNP Student ____________________________

Place of employment: _______________________________________

Unit/Department ________________________

Dear Employer:

The student named above, who is an employee of your institution, has requested to complete his/her doctoral practice hours at your institution. These practice (clinical) hours may not be completed during the student's normal work time, or any time that the student is carrying out any responsibilities that are a requirement of their official position.

Any practice hours must be completed outside those hours of expected clinical, administrative or service hours deemed part of their employment. This clinical practicum begins on _____________________ and ends on ___________________.

By signing this form, I acknowledge that ______________________________________ will not
DNP Student's Name

be using work time as part of this clinical practicum experience.

Organization/Administrative Director Signature____________________________________

Position/Title________________________________

Name of Student's Preceptor___________________________

Position/title________________________________ Date______________