



**Section II: Verification of Clinical Nurse Specialist Program**

**Instructions to Registrar:** Please complete Section II and return both pages of this form **along with an official school transcript**, directly to the New York State Education Department at the address at the end of this form. **This form will not be accepted if returned by the applicant or any other party.**

**Note:** If the applicant has completed more than one program, a Form 2 must be submitted for each program.

a) It is hereby verified that: \_\_\_\_\_  
(Section I, item 6.)

has completed a program qualifying for clinical nurse specialist and the degree/diploma listed below has been awarded. The official program title completed by the applicant is as follows:

Official program title: \_\_\_\_\_

b) The program contained: \_\_\_\_\_ hours of classroom instruction and \_\_\_\_\_ hours of preceptorship with a clinical nurse specialist or physician.

c) Degree/diploma awarded: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**Certification**

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.

Signature of Registrar: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Title or official position: \_\_\_\_\_

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

**(SEAL)**

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Clinical Nurse Specialist Unit, 89 Washington Avenue, Albany, NY 12234-1000.**