The University of North Carolina at Chapel Hill School of Nursing

REQUEST FOR UNOFFICIAL EVALUATION OF PRIOR MSN COURSEWORK

INSTRUCTIONS: Please provide the information below. This information will guide our evaluation of your transcripts to determine your plan of study. Attach this form to your Master's transcript. We will mail the evaluation to your address as listed below. Please fax or mail your information to:

Office of Admissions and Student Services, UNC Chapel Hill School of Nursing
CB# 7460, 1200 Carrington Hall, Chapel Hill, NC 27599-7460
Phone (919) 966-4260 ♦ Fax (919) 966-3540

Name of Candidate: ______________________________ Date: ______________

Street Address: ____________________ City, State, Zip Code: ____________________

Phone: (Home) ______________ (Work) ____________ Email: ________________

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1. Post-Master's Certificate Program you are applying for **(check all that apply):**
   - ☐ Primary Care Nurse Practitioner
     - ☐ Adult-Gerontology ☐ Adult-Gerontology|Oncology Focus
     - ☐ Family ☐ Pediatric
   - ☐ Psychiatric Mental Health: How many years of nursing experience have you had in a psychiatric setting? ___ ___
     - ☐ PMH Nurse Practitioner (NP) : ____ Family or ____ Adult focus

     PMH curriculum may be revised by the time of applicant admission to include only the PMH Family focus.
   - ☐ Health Care Systems: Please indicate area of interest: ________________

     (Administration, Education, Informatics, Clinical Nurse Leader, Clinical Nurse Leader/Educator)

2. Graduate Educational Background:

School	*Role Preparation (e.g. NP, CNS, Administration) (include population or specialty role)*	*Degree Earned & Date Conferred*

3. Are you currently employed? ☐ Yes ☐ No What is your position/title? ____________________

4. In what capacity are you currently practicing?

   ☐ NP ☐ CNS ☐ Both NP and CNS ☐ Other, please specify: ____________________

5. If you are not currently practicing as a NP or CNS, when is the last time you actively practiced in the role of a NP or CNS?

   Date last practiced as NP: ______________ *Date last practiced as CNS:* ______________

6. If you are applying to a post-master's NP or CNS certificate program, what is your current certification status?

   (Check all that apply)

   ☐ I am certified as a NP. ☐ I am certified as a CNS. ☐ I am not currently certified.

Certifying Body	*Specialty Area of Certification*	*Expiration Date*

7. If you are a NP, in what state(s) are you approved to practice? ____________________

05/2011

This evaluation is unofficial and used for advising purposes only. An official plan of study will be determined upon admission into the University, from official transcripts sent by registrars of other institutions. Course requirements may change or be modified to meet the School and national competencies.