Verification of Employment Form

Your employee is requesting a waiver for the clinical component of a specialty certificate clinical program at Duke University School of Nursing. Please complete and sign the form below.

Student Name:			
Credentials:			
Name of Practice:			
Address:			
Phone:			
Practice website:			
Supervising MD (if applicable):			
Type (specialty) of practice:			
Student employed at this practice since:	**Yes ( )** **No ( )**	**Full time ( )**	**Part time ( )**
Diagnoses commonly managed by NP:			
The employee is engaged in an active clinical practice, evaluating and managing patients at this site:	**Yes ( )** **No ( )**		
Average number of Patients seen monthly:			

Practice Site (Supervising MD or Site Practice Manager)

____**(Name Printed/Signed) DATE:** ________________________

Student Signature

____**(Name Printed/Signed) DATE:** ________________________

Duke University School of Nursing-Faculty

____**(Name Printed/Signed) DATE:** ________________________

[ ] Exemption Approved--- Faculty Initials and Date __________________________

[ ] Exemption NOT Approved Faculty Initials and Date ________________________