



School of Nursing Clinical Nurse LeaderSM (CNL[®])
Education Program Verification Form
(Please type or print all responses.)
Email to cnl@aacn.nche.edu

This statement must be completed and signed by the dean/chief academic officer for the school of nursing. The form must be on file with the Commission on Nurse Certification to document eligibility for graduates of the institution's Clinical Nurse Leader program to sit for the CNL Certification Examination.

Name of Institution/School of Nursing: _____

Mailing Address: _____

I, _____ (Dean/Chief Academic Officer of the School of Nursing) hereby verify that the Clinical Nurse Leader (CNL) master's degree or post-master's certificate program at _____ (name of institution) prepares individuals with the outcome competencies delineated in AACN's white paper on *The Education and Role of the Clinical Nurse Leader*. In addition, the CNL education program at this institution requires each student to complete as part of their formal CNL educational program a minimum of 300 total hours practicing in the CNL role in a clinical immersion experience; and a minimum of 400 total clinical hours (may include the 300 clinical immersion hours).

CNL Education Program Model(s) (check all that apply):

- ☐ **Model A** – Master's degree program designed for BSN graduates
- ☐ **Model B** – Master's degree program for BSN graduates that includes a post-BSN residency that awards master's credit (Amount of credit awarded for residency (credit hours) _____)
- ☐ **Model C** – Master's degree program designed for individuals with a baccalaureate degree in another discipline (second-degree program)
- ☐ **Model D** – Master's degree program designed for ADN graduates (RN-MSN)
- ☐ **Model E** – Post-master's certificate program designed for individuals with a master's degree in nursing in another area of study

Date first students were admitted to the Clinical Nurse Leader program: _____ (MM/DD/YYYY)

I certify that the above information regarding the CNL education program is complete and accurate.

Name of Dean of Institution/School of Nursing **Date**

☐ **I Accept** (By selecting the "I Accept" button, you are signing this Application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Application.)

E-mail: _____ **Phone Number:** _____

Faculty Contact for the CNL Exam Administration: _____

Phone Number: _____ **E-mail:** _____