

MASTER'S DEGREE PROGRAM OF STUDY

STUDENT'S NAME: _____

URI ID#: _____

DEPT/PROGRAM: Nursing: CNS Psychiatric/Mental Health

DEGREE: M.S. (Thesis) (Non-Thesis)
(circle appropriate)

I hereby certify that all course work taken at the University of Rhode Island is included below and that grades are indicated for all courses completed.

Student's Signature

Date

PROGRAM CREDIT COURSES CONSTITUTING THIS STUDENT'S MASTER'S PROGRAM

Course Dept/No.	Title	Credits & Grade	Course Dept/No.	Title	Credits & Grade
NUR 500	Gen'l Study Nurs Knowl for Nurs Pract	4	PSY 601	Physiological Psychology	3
NUR 503	Expanded Nursing Assessment Skills	3			
NUR 505	Nursing Research	3			
NUR 507	Theory of Practice	3			
NUR 510	Nursing Leadership in Health Policy	3			
NUR 511	Adv. Mental Health Nursing I	3			
NUR 512	Practicum in Adv. Mental Hlth Nsg IA	3			
NUR 515	Practicum in Adv. Mental Hlth Nsg IB	3			
NUR 516	Adv. Mental Health Nursing II	3	Expected Date of Graduation:		
NUR 517	Practicum in Adv. Mental Hlth Nsg II	3	NUR 599	Thesis:	
NUR 519	Psychopharmacotherapeutics	3		Transfer Credit	
NUR 520	Graduate Study Seminar	1		Total Credits	41

PROGRAM CREDIT TO BE TRANSFERRED FROM OTHER INSTITUTIONS

Official transcript and certification that courses are graduate level courses acceptable for program credit at the other institution must be provided before approval is final.

Course Dept/No.	Title	School	Grade	Credit (Qtr/Sem)	Date Compl.	Equiv. Credit

COURSES TO BE TAKEN AS NON-PROGRAM CREDIT

Course Dept/No.	Title	Credits & Grade	Course Dept/No.	Title	Credits & Grade

ADVISOR/MAJOR PROFESSOR: _____

DATE: _____

DEPARTMENT CHAIRPERSON: _____

DATE: _____

DEAN, GRADUATE SCHOOL: _____

DATE: _____