F-1 Student Curricular Practical Training (CPT) Attestation

Date: ___________________

To Whom It May Concern:

I hereby verify that ____________________________________ (full name of student) has been offered a clinical rotation at Texas Woman's University for school term ________________ (i.e., Spring or Fall) under the following terms:

Course Start Date_____________
Course End Date_______________
Number of course hours__________

Name of Institution providing clinical rotation_____________________________________
Physical Address____
(No PO Box) Street Address City State Zip code

Student Level:___________________________________ (e.g., Junior, Senior) Role and responsibilities of the position:

BSN Program Director/Clinical Coord:_____________________________________
Program Director/Clinical Coord Email:___________________________________
Program Director/Clinical Coord Phone: ___________________________________

____ ______________
_ Signature of BSN Program Director/Clinical Coord Date