Name

Title

Institution/Hospital/Organization

Address

City, State, Zip Code

Email Address

Phone Number

**Date**

Dear Francis Marion University, Post-Masters PMHNP Certificate, Admission Panel:

I am writing to verify the clinical practice experience of **[Applicant/Nurse Practitioner's Name]** during their tenure at **[Institution/Hospital/Organization].** **[Applicant/Nurse Practitioner's Name]** has successfully completed at least 500 hours of clinical practice in the area of Psychiatric Mental Health as a Nurse Practitioner in the **[primary care]** setting, encompassing the diagnosis, treatment, and management of patients with psychiatric-mental health disorders.

During their clinical practice, **[Applicant/Nurse Practitioner's Name]** has demonstrated proficiency in assessing, diagnosing, and treating patients with psychiatric disorders. They have displayed a comprehensive understanding of the neuroscience behind psychiatric disorders and have effectively employed evidence-based interventions in their practice.

Furthermore, **[Applicant/Nurse Practitioner's Name]** has exhibited adeptness in medication management for psychiatric disorders, including but not limited to psychopharmacological interventions. Their approach to patient care has always been holistic, integrating pharmacotherapy and other adjunctive therapies to optimize patient outcomes. In addition to clinical interventions, **[Applicant/Nurse Practitioner's Name]** has consistently engaged in collaborative care, referring patients to external behavioral health resources when necessary. Their commitment to interdisciplinary collaboration ensures that patients receive comprehensive care tailored to their individual needs.

Overall, [Nurse Practitioner's Name] has demonstrated exemplary clinical competence, professionalism, and dedication throughout their clinical practice. It is with confidence that I verify their fulfillment of the 500 hours of clinical practice in this specialized area. Please do not hesitate to contact me if further information or clarification is needed regarding their clinical practice experience.

Sincerely,

Name

Title

Contact Information