

Faculty Degree Plan Kansas State Board of Nursing

Name: _____

Please answer the following questions:

Date	
Nursing License Number & State <small>(if other than Kansas)</small>	
Program of Employment	
Name of Program in which Enrolled	
Degree to be obtained	
Date of Enrollment <small>(must be currently enrolled for Degree plan to be approved)</small>	
Projected Date of Completion <small>(completed within six years)</small>	

(May attach degree plan from the school where enrolled if preferred):

Name of Course	Enrollment Date	Date of Completion	# Credit hours

Notification and rationale should be submitted when the degree plan is not followed. **Upon completion of the degree, a transcript showing completion of the program should be submitted.**