PENNSYLVANIA STATE BOARD OF NURSING

VERIFICATION OF LICENSURE

Section A. ***Completed by Applicant only. Contact authority to confirm fee for verification.***

Name: _____ **Date of Birth:** _____
Last First Middle Maiden Name MM DD YYYY

Current Address: _____
Street City State Zip Code

Social Security #: _____ - _____ - _____

Original Licensure: _____ _____
State License Number

Name as it appears on original license: _____

I certify that all of the above information is correct. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904 relating to unsworn falsification to authorities and may result in sanctions of my license or certificate and/or disposition of civil penalties. I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S. §4911.

Signature: _____ **Date:** _____

Section B. ***Completed by Original Licensing Authority only.***

This is to certify that _____ **was issued license number** _____
Applicant 's Name

Date Issued: _____ / _____ / _____
MM DD YYYY

Type of License Issued: [ ] Registered Nurse [ ] Practical Nurse

Basis for licensure:
[ ] Examination [ ] Other _____

Current licensure status: [ ] Active [ ] Inactive [ ] Lapsed

Has this license ever been disciplined in any manner or are disciplinary charges pending?
[ ] No [ ] Yes (If yes, please send certified copies of Board actions)

Basic Nursing Education Program: **Location:** (City, State/Province/Territory):

_____ _____

Type of Program: [ ] Registered Nurse [ ] Practical Nurse **Approved by State/Province/Territory:** [ ] Yes [ ] No

Completion Date: _____ / _____ / _____ **Awarded:** [ ] Baccalaureate [ ] Associate [ ] Diploma [ ] Other _____
MM DD YYYY

Exam Information:

[ ] NCLEX PN Results: _____ Exam Date or Series: _____

[ ] NCLEX RN Results: _____ Exam Date or Series: _____

[ ] SBTPE _____ _____ _____ _____ _____ Exam Date or Series: _____
MED SUR OBS PED PSYCH

[ ] Other Results: _____ Exam Date or Series: _____

Original Signature: _____

Title: _____

(SEAL)

Name of Licensing Authority: _____

Location: _____

Date: _____

Licensing Board mail form to:

PA State Board of Nursing

P.O. Box 2649

Harrisburg, PA 17105-2649

THIS FORM IS VALID FOR ONE YEAR

Rev. 3-11-2010