



Form A

Verification of Licensure

(May be photocopied)

Part 1-General Information: Please complete and forward to the state of original licensure by examination; and to the state where you hold a current, valid unrestricted license (any jurisdiction of the National Council of State Boards of Nursing) if not the same as the state of original licensure by examination. Contact the verifying state for fee information.

DO NOT complete this form if you are verifying a NURSYS® state. Check www.nursys.com for a list of NURSYS states.

Name: (Last) (First) (Middle) (Maiden)

Social Security Number*: Date of Birth:

Address:

City, State, Zip:

Name of Nursing Education Program:

City, State, and Country of School:

Program Completion Date: Licensure: RN LPN

Original License Number: Date of Original Licensure:

Your name under which originally licensed: (Last) (First) (Middle)

I hereby authorize the State Board of Nursing of my state of original licensure/current state of licensure (please list state) to furnish the Ohio Board of Nursing with the information requested in Part 2 on the reverse side of this form.

Signature: Date:

* Your social security number is required by state and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the National Practitioner Data Bank (Public Law 100-93, Sec. 1921 of the Social Security Act, as amended; 45 C.F.R. pt. 60); reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

Part 2-Licensure Information-To be completed by the State Board of Nursing only and mailed directly to the Board. An application is incomplete without this form being received by the Ohio Board of Nursing.

Please complete this form and return to the Board within 30 days of receipt to the address below:

Ohio Board of Nursing
Attn: Licensure Unit
 17 South High Street, Suite 660
 Columbus, OH 43215-3466

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THIS SECTION IS TO BE COMPLETED BY THE STATE OF ORIGINAL LICENSURE ONLY

Name of Nursing Education Program Completed: _____

City, State, and Country of Program: _____

Date of Completion: _____ Was this program approved? Yes No

State Board Test Pool Examination (SBTPE) Results						NCLEX®		
Registered Nurse						LPN	RN	LPN
	Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children			
Standard Scores								
Series/Form No.								

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THIS SECTION IS TO BE COMPLETED BY THE STATE WHERE THE APPLICANT HOLDS A CURRENT, VALID, AND UNRESTRICTED LICENSE

Name of Nurse: _____

License Number of Nurse: _____ RN LPN Date of Issuance: _____

Current License Status: Active Inactive Lapsed Expiration Date: _____

Licensed by: Examination Endorsement Other _____

Is there any pending disciplinary action against this license? Yes No If yes, attach explanation.

Has this license ever been encumbered (revoked, suspended, surrendered, restricted, limited, placed on probation, etc.)? Yes No If yes, attach explanation.

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THIS SECTION IS TO BE COMPLETED BY THE STATE BOARD OF NURSING REPRESENTATIVE COMPLETING EITHER SECTION ABOVE

I certify that the above information accurately represents the information on file with the State Board of Nursing, for the above named nurse.

Signed and the State Board of Nursing seal affixed this _____ day of _____, 20_____.

(SEAL)

Signature _____

Title _____

State _____