STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF REGISTERED NURSING
P.O Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | www.rn.ca.gov

Ruth Ann Terry, MPH, RN, Executive Officer

VERIFICATION OF LICENSE

1. Send this form to the State Board of Nursing where you have a current and active license. The board of nursing may require a processing fee. If you are licensed in a state that is a member of the Nursys® verification system, visit www.nursys.com to complete the online verification request application process.
2. **INTERNATIONAL GRADUATES:** Send form to the state of current license. If you took the examination in a different state, make a copy of this form and send the form to that state also.

PART I: To be completed by APPLICANT and forwarded to appropriate licensing boards.

Name: *(Last, First, Middle)*		**Previous Names:** *(Including Maiden)*	
Current Street Address of Record:	**City:**	**State:**	**Zip Code:**
Name as it Appeared on Original License: *(Last, First, Middle)*	**Date of Birth:** *(Month/Day/Year)*	**Social Security Number:**	
State of Current Licensure:	**Issue Date of Current License:**	**Current License Number:**	
State of Original Licensure:	**Issue Date of Original License:**	**Original License Number:**	

I hereby authorize all identified Boards of Nursing to release my licensure data to the California Board of Registered Nursing.

***Signature*: _____ Date: _____**

PART II: To be completed by licensing board and sent to the California Board of Registered Nursing listed at the top of this form.

This is to certify that this applicant was issued a license number to practice as a registered nurse:

Applicant Name: _____ Date Issued: _____

License Number: _____ Expiration Date: _____

Licensed by: ☐ **Endorsement** ☐ **Examination** ☐ **Waiver**
Current Licensure Status: ☐ **Active** ☐ **Inactive** ☐ **Lapsed**

Has license ever been REVOKED, SUSPENDED, placed on PROBATION, or DISCIPLINED in any way? ☐ **Yes** ☐ **No**
If yes, please attach certified documents. **Reinstated?** ☐ **Yes** ☐ **No**
Date Reinstated: _____

Is there any PENDING disciplinary action or pending investigation against this licensee? ☐ **Yes** ☐ **No**
If yes, please attach information.

Name of Professional Nursing Program:	**Approved by State?** ☐ **Yes** ☐ **No**	**Graduated from:** ☐ **High School** ☐ **H.S. Equivalency** ☐ **10th Grade**
Location: *(City, State/Country)*	**Graduation Date:**	**Type of Nursing Program** ☐ **ADN** ☐ **DIP** ☐ **BSN** ☐ **MSN** ☐ **Other**

Examination Passed:
☐ **NCLEX-RN** ☐ **SBTPE** ☐ **Canadian Five-Part** **Taken in English?** ☐ **Yes** ☐ **No**

Scores: SBTPE/Canadian	**Medical**	**Surgical**	**Obstetric**	**Pediatric**	**Psychiatric**	**Series or Exam Date:**
NCLEX-RN _____	_____	_____	_____	_____	_____	

***Signature*: _____ Title: _____**

Board of Nursing: _____ Date: _____

[BOARD SEAL]

(Rev 11/03)