State of California Department of Consumer Affairs

BOARD OF REGISTERED NURSING
P O Box 944210, Sacramento, CA 94244-2100
TDD (916) 322-1700
Telephone (916) 322-3350
www.rn.ca.gov

VERIFICATION OF NURSE PRACTITIONER (NP) CERTIFICATION BY NATIONAL ORGANIZATION/ASSOCIATION OR STATE BOARD
METHOD 2

A. TO BE COMPLETED BY APPLICANT: Please complete Part A and submit to the applicable national organization/association or state board to verify your nurse practitioner certification status. **A fee is required by the national organization/association or state board for the processing of the verification form.** Please print or type.

Name: (Last) (First) (Middle)	Previous Names (Including Maiden Name):
Address: (Number & Street)	Date of Birth: (Month) (Day) (Year)
(City) (State) (Zip Code)	Social Security Number (Mandatory):
Telephone Number: Home ( ) Work ( )	California RN License Number: Expiration Date:
Name of Academic Program:	Specialty:
Entrance and Completion Dates:	Type of Program:

Signature of Applicant:_____Date:_____

B. TO BE COMPLETED BY THE CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION OR APPLICABLE STATE BOARD: Please complete Part B regarding the above named applicant and return to the Board of Registered Nursing.

Name of Certifying National Organization/Association or State Board:	Telephone Number: ( )
Address: (Number & Street) (City) (State) (Zip Code)	Method of Certification:
Certificate Number:	Original Date of Certification:

Nurse Practitioner Specialty Area:

Current Renewal Cycle Dates for Certification/Recertification: From: (Month) (Year) To: (Month) (Year)
(If not applicable, please explain.)

I certify under penalty of perjury that the documentation regarding the nurse practitioner certification status for the above named applicant is true and correct.

Signature:_____Date:_____

Title:_____Telephone Number:(____)_____ **(OFFICIAL SEAL)**