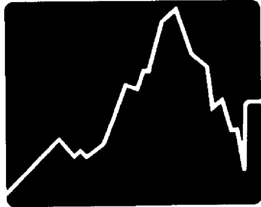

COMMONWEALTH OF VIRGINIA
Department of Health Professions - Board of Nursing
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
(804)367-4515 – PHONE (804) 527-4455 – FAX
web: **www.dhp.virginia.gov/nursing** email: appsupportdocs@dhp.virginia.gov

LICENSE VERIFICATION FORM – NON-*NURSYS* PARTICIPATING STATES

APPLICANT: Complete the top portion only and send to the Board of Nursing in the state where you were *originally* licensed by exam. **If your state participates in the *Nursys* License Verfication System** go to https://www.nursys.com/NLV/NLVTerms.aspx to request your verification.

Name: Last First Middle	Social Security Number:

Address

RN License No.:	**LPN** License No:	Year Issued:

Name on Original License:

TO THE BOARD OF NURSING: Please provide the information requested and return the form to the **Virginia Board of Nursing**

APPLICANT'S FULL NAME:

Last:	First :	Middle:	Maiden:

Was school approved at time applicant graduated: Yes ☐ No ☐	Graduation date/year:

REGISTERED NURSE (RN)

School:______________________________

Location:______________________________

Type of Program: AD ☐ BS ☐ DIP ☐ MSN ☐

Program in English: Yes ☐ No ☐

NCLEX #:________ NCLEX Score:__________

CRNE:__________ OTHER:______________

SBTP Series #:_______

Scores:

Medical Nursing: ____________

Surgical Nursing: ____________

Obstetric Nursing: ____________

Psychiatric Nursing:____________

Pediatric Nursing: ____________

LICENSED PRACTICAL NURSE (LPN)

School:______________________________

Location:______________________________

Licensed on basis of:

Graduation from school of practical nursing: ☐

Equivalence provision of law: ☐

Waiver provision of law: ☐

SBTP Series #:__________

NCLEX #:____________

OTHER:_____________

SCORE:_____________

LICENSE NUMBER ______________ was granted on ______________ by: Examination ☐ Endorsement ☐ Waiver ☐ Status of license: Current ☐ Lapsed ☐ Inactive ☐

Has license ever been suspended, revoked or otherwise disciplined? Yes ☐ No ☐. If yes, please attach certified copy of any order issued by the Board.

I *certify* the above information to be true in every respect, according to the record on file with the ____________ State Board of Nursing.

______________________ ______________________

Date **Executive Director**

Revised: 7/30/16