State of Ohio Board of Nursing *www.nursing.ohio.gov*
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

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)

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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
(NOT Ohio Board of Nursing)
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.

Form A Continued on Next Page

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_____

2018