VERIFICATION OF LICENSE - NURSE

APPLICANT: Complete Applicant section and mail to all state boards of nursing where you hold or ever held a license (including where you took the licensing examination). **CONTACT THAT BOARD OF NURSING FOR THEIR PROCEDURES AND FEES.** If the state is a member of the NURSYS System, you will need to contact them toll free at (866) 819-1700 to request a license verification form or you may download the form from their website at: **www.nursys.com**

APPLICANT

Legal Name (First, Middle)	(Last)	Other Names Used (Include maiden name)
Address (Include Apt. No., City, State and Zip Code)	Social Security No.	Personal Email Address
	Date of Birth	Phone No.

LICENSE NUMBER	DATE ISSUED:	Type of Registration: ☐ REGISTERED NURSE ☐ PRACTICAL NURSE

I hereby authorize the nursing licensing agency in the State of ____________________ to furnish to the Department of Commerce & Consumer Affairs, State of Hawaii, the information below.

SIGN HERE: ____ Date: ____________________

LICENSING AGENCY ONLY

This is to certify that the above-named individual was issued license number: ______________________________

Social Security Number: ______________________________

to practice: ☐ Registered Nursing ☐ Practical Nursing

Date of Issuance: ______________________________

licensed by: ☐ Examination ☐ Endorsement ☐ Waiver

Current license status: ☐ Active ☐ Inactive ☐ Lapsed

Date license expires: ____________________

Has this license ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation)? . . . . ☐ Yes ☐ No

If "YES", please send a copy of your board's:
1) Administrative Action
2) Final Order

EXAMINATION INFORMATION	**REGISTERED NURSE (NCLEX)**	**REGISTERED NURSE (S.B.T.P.E.)**					**PRACTICAL NURSE (NCLEX or SBTPE)**
		Medical Nursing	**Psychiatric Nursing**	**Obstetric Nursing**	**Surgical Nursing**	**Nursing of Children**	
Standard Scores							
Series/Form No.							

Number of times applicant wrote the examination?

Name of U.S. Accredited Nursing Education Program Completed (or non-U.S. Accredited Nursing Education Program approved/recognized by this State Board as equivalent to U.S. Accredited Nursing Education Program.)

Location (City and State)	Year of Graduation:

SEAL

Signature: ______________________________

Title: ______________________________

State: ____________________ Date: ____________________

TO THE BOARD: Return this form <u>directly</u> to: Hawaii Board of Nursing
P.O. Box 3469
Honolulu, HI 96801

This material can be made available for individuals with special needs. Please call (808) 586-3000 to submit your request.

NSG-03 1117R