VERIFICATION OF RN/APRN LICENSE - (Applicant Applying for APRN License)

Access this form via website at: **cca.hawaii.gov/pvl**

State of Hawaii
Board of Nursing
P.O. Box 3469
Honolulu, HI 96801

APPLICANT

APPLICANT: *Complete top of this page and forward to state of license. (NOT HAWAII)* Contact your state board for any fees associated with processing your verification. NURSYS will not verify your APRN license, so you must send this form to each state to verify each APRN license.

Name (First, Middle)	(Last)	Other Names Used (Include Maiden Name)

Address (Include Apt. No., City, State and Zip Code)	Social Security No.
	Phone No.

License Number	Date Issued	**PERSONAL** E-Mail Address:	Type of Registration:
			◯ Registered Nurse ◯ Advanced Practice Registered Nurse

I hereby authorize the nursing licensing agency in the State of _____ to furnish to the Department of Commerce and 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 the following:

☐ **REGISTERED NURSE LICENSE (complete only if active license is maintained)** Date of Issuance: _____

Licensed by: ☐ examination ☐ endorsement ☐ waiver

Current license status: ☐ Active ☐ Inactive ☐ Lapsed

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

(If "YES", please submit certified documents relating to disciplinary action of this license including Findings of Fact, Conclusions of Law, Recommended Order, Final Order, and whether license has been restored, reinstated, or new license issued).

Date license expires: _____

☐ **ADVANCED PRACTICE REGISTERED NURSE (complete only if active license is maintained)** Date of Issuance: _____

Licensed by: ☐ Graduate-level degree ☐ National Certification ☐ Other: _____

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

(If "YES", please submit certified documents relating to disciplinary action of this license including Findings of Fact, Conclusions of Law, Recommended Order, Final Order, and whether license has been restored, reinstated, or new license issued).

Date license expires: _____

SEAL

Signature: _____

Title: _____

State: _____

Date: _____

*TO THE LICENSING AGENCY: Return this form **directly** to the Hawaii Board of Nursing.* **DUPLICATE AS NEEDED**

NSG-28 0816R

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

Print Form