Nursing License Verification Form (To be completed by the licensing authority only)

Section 1: Instructions for Licensing Authority
Please provide the information requested below and return this form to Educational Perspectives, nfp:

Educational Perspectives, nfp
PO Box A3462
Chicago, IL 60690-34

Section 2: Print or Type

Name of Applicant: ____________________________________________________________

Name of Nursing Licensing Center: ____________________________________________

Address of Nursing Licensing Center: __________________________________________

Email: ______________________ Phone: ______________________ Fax: ______________________

Date of Issue of Nursing License: _____ / _____ / _____  Expiration of Nursing License: _____ / _____ / _____
(month/day/year) (month/day/year)

Legal Professional Title: ______________________________________________________

Scope of Practice: ____________________________________________________________

Nursing License Number: _____________________________________________________

The License was Validated by: _________________________________________________

Current Status of Nursing License: ____________________________________________

If License was Restricted, Revoked, Suspended or Placed on Probation, please explain: ______________________________________________________________

________________________________________

Authority that Regulated the Licensing of Nurses in Your Country at the time: ______________________

License Verified by

Name: ________________________________________________________________

Title: _________________________________________________________________

Signature: _______________________________________________________________________

Date: _______________________________________________________________________

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