



**COMMONWEALTH OF VIRGINIA**  
 Department of Health Professions - Board of Nursing  
 Perimeter Center  
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### LICENSE VERIFICATION FORM

**TO THE APPLICANT** – Complete the top portion only and send to the Board of Nursing in the state where you were licensed by examination (fee may be required).

Name – Last	First	Middle	Social Security Number or Virginia DMV Number
Address			
R.N. License No.:		L.P.N. License No.:	
Name on Original License:		Year Issued:	

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

APPLICANT'S FULL NAME:

Last	First	Middle	Maiden
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Was school approved at time applicant graduated? Yes _____ No _____	Year of Graduation: _____
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REGISTERED NURSE	LICENSED PRACTICAL NURSE
School _____	School _____
Location _____	Location _____
Type of Program: AD__BS__DIP__ Program in English? Y__N__	Licensed on the basis of: _____
SBTP SERIES # _____ NCLEX # _____	Graduation from school of practical nursing _____
CRNE _____ OTHER: _____	Equivalence provision of law _____
SCORES:	Waiver provision of law _____
Medical Nursing _____	SBTP SERIES # _____ NCLEX # _____
Surgical Nursing _____	OTHER: _____
Obstetric Nursing _____	SCORE: _____
Psychiatric Nursing _____	
Nursing of Children _____	
NCLEX _____	

LICENSE NUMBER \_\_\_\_\_ was granted on \_\_\_\_\_ by exam \_\_\_\_\_ 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.

**SEAL**

Date

Executive Director