MAINE STATE BOARD OF NURSING

158 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA MAINE 0433
(207) 287-1133

VERIFICATION OF LICENSED PRACTICAL NURSE LICENSURE

Submitted to original state of licensure when the state does not participate in NURSYS verification and Canadian and foreign licensing authorities

To _____ **Board of Nursing**

Name of Applicant _____

Present Address _____

_____

License Number _____ **Date of Birth** ___/___/___ **Social Security Number** ___–___–___

INFORMATION BELOW TO BE COMPLETED BY THE BOARD OF NURSING IN YOUR STATE OF ORIGINAL LICENSURE

EDUCATION

High School Diploma: ☐ YES ☐ NO ☐ G.E.D.

Nursing Program: State Accredited? ☐ YES ☐ NO Type: ☐ Associate Degree ☐ Baccalaureate Degree ☐ Diploma

Name of Nursing Program _____

Address _____

Date of Entrance ___/___/___ Date of Graduation ___/___/___ Length of Program _____

LICENSURE

License Number _____ Date Issued ___/___/___ Expiration Date of Current License ___/___/___

Issued by: ☐ Exam ☐ Endorsement ☐ Waiver

Has license ever been suspended, revoked, probated, reprimanded, or limited/restricted? ☐ YES (please attach explanation) ☐ No

EXAMINATION

Results of State Board Test Pool Examination/NCLEX (please indicate if exam was taken more than one time) Series Number: _____

Scores: *if applicant did not write SBTPE/NCLEX, specify type of test and list subjects and grades on back

Medical Nursing _____ Psychiatric Nursing _____

Obstetric Nursing _____ Surgical Nursing _____

Nursing of Children _____ Comprehensive NCLEX _____

Canadian Exams: ☐ CNATS ☐ Provincial Taken in: ☐ English ☐ French

NAME & TITLE _____

STATE _____

DATE _____

(SEAL)