

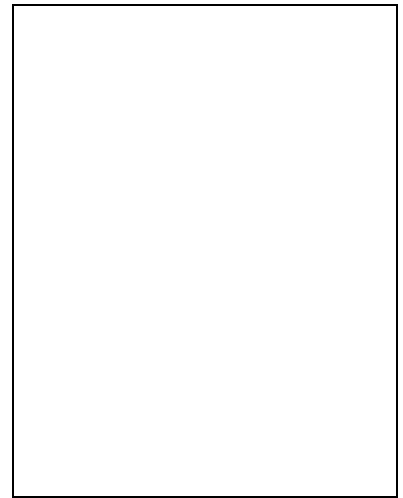


THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Nursing

550 West 7th Avenue, Suite 1500
Anchorage, AK 99501
Phone: (907) 269-8161 Fax: (907) 269-8196
Email: license@alaska.gov
Website: www.nursing.alaska.gov



VERIFICATION OF NURSING LICENSE

Section I: APPLICANT - Complete Section I and mail to the state(s) or Canadian Province where you received initial licensure, AND to a state or province where you hold a CURRENT license. Send only one form if your initial license is current. If the state where you hold or held licensure is a member of the NURSISYS System, please complete your verification online at: www.nursys.com or contact the National Council of State Boards of Nursing to request a verification form. If you have already released your information via Nursys, you do not need to forward this form to the corresponding licensing board.

I have released my license verification(s) via the Nursys on-line verification system: Yes No

Last Name First Middle Initial Maiden

Other Names:

Address: Street City State Zip Code

Birth Date: Social Security No.:

License No.: RN: LPN: Expiration Date:

Section II: BOARD OF NURSING - Please complete the applicable portions of this form on behalf of the nurse named above and return to the Alaska Board of Nursing at the address at the top of the page.

Nursing School and Location:

Graduation Date: Accredited: Yes No

Type of License: RN: LPN/LVN: License No.:

Method of Licensure: Exam: Endorsement: Waiver:

Original Issue Date: Expiration Date:

License Status: Current: Inactive: Lapsed:

Pending disciplinary action or pending investigation against this licensee? Yes No

If Yes, please explain:

Former disciplinary action: Has this license ever been ENCUMBERED in any way? Yes No

If Yes, please explain:

VERIFICATION OF EXAMINATION AND SCORES

State Board Test Pool Exam: RN: _____ LPN: _____ Series: _____ Scores: _____

Medical: _____ Psych.: _____ Obstetric: _____ Surgical: _____ Children: _____

NCLEX Scores: RN: _____ LPN: _____ Series: _____ Other: _____

NCLEX Scores: CAT RN: _____ LPN: _____ Date Taken: _____

Signature: _____ **Title:** _____

Board of Nursing: _____ **Date:** _____

BOARD SEAL

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