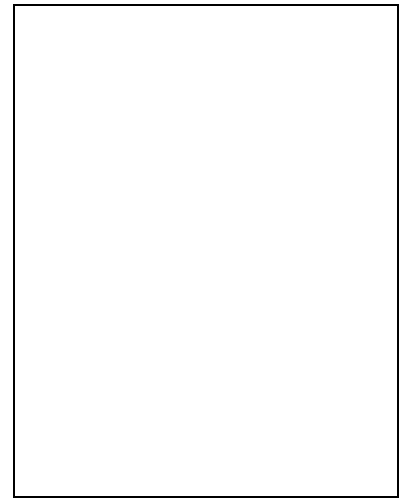




THE STATE of ALASKA

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



Board of Nursing

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Anchorage, AK 99501

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Email: boardofnursing@alaska.gov

Website: www.nursing.alaska.gov

PROFESSIONAL ACTIVITIES VERIFICATION

Applicant: Complete Section A and have the organization/agency where the professional activities were performed complete Section B. If you selected "professional activities" as one of the methods of satisfying continuing competency, then you must verify a minimum of 60 hours of professional activities required under 12 AAC 44.620 and obtained within the last biennial licensing period. Provide copies of this form to as many organizations/agencies as needed for verification.

Section A:

I, \_\_\_\_\_, am applying for an Alaska nursing license to practice as a

[ ] registered or [ ] practical nurse and hereby authorize you to release information as required on this form.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

License Number: \_\_\_\_\_

Section B: To be completed by organization/agency where services were performed. Complete all sections below.

By my signature below, I attest that the above-named nurse performed "professional activities (without compensation)" using nursing knowledge that contributed to the health of individuals or the community during the time period below:

Dates of Professional Activities: \_\_\_\_\_ The number of hours performed: \_\_\_\_\_
(list month/year through month/year)

Professional activities must be performed without compensation and satisfied through one or more of the following methods (check all that apply):

- [ ] work with a professional nursing or health-related organization (what type of work?);
[ ] authoring or contributing to an article, book, or publication related to health care;
[ ] development and oral presentation of a paper before a professional or lay group on a subject that explores new or current areas of nursing theory, technique, or philosophy;
[ ] design and conduct a research study relating to nursing and/or health care;
[ ] other professional activities approved by the board.

Describe the professional activities: \_\_\_\_\_

\_\_\_\_\_

Verified by: \_\_\_\_\_

Title/Position: \_\_\_\_\_

Name of Organization: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_



PLEASE RETURN COMPLETED FORM DIRECTLY TO THE ALASKA BOARD OF NURSING. FAXED COPIES NOT ACCEPTABLE.