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
E-mail: license@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 Alaskanursing license to practice as a ☐ registered or ☐ practical nurse and hereby authorize you to release information as required on this form.

Name:_____

License No.: _____

Signature: _____

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 (list month/year through month/year)

➡ **The number of hours performed:** _____

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: _____

Address: _____

_____

Phone:_____Date: _____

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