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 30 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: __________________________________________
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.

08-4472 (Rev. 01/27/14)