



MAINE STATE BOARD OF NURSING

158 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA, MAINE 04333-0158
(207) 287-1133

VERIFICATION OF REGISTERED PROFESSIONAL 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)