



Washington State Department of
Health
 Nursing Care Quality Assurance Commission
 P.O. Box 47864
 Olympia, WA 98504-7864
 360-236-4703

Education Verification for Licensed Practical Nurse Educated Outside the United States

Applicant: Complete this section and mail to your school of nursing which you graduated.

Name	Last	First	Middle Initial
Date of Birth (mm/dd/yyyy)		Other names used	
Address			
City	State	Zip Code	County
High School Graduate <input type="checkbox"/> Yes <input type="checkbox"/> No			Social Security Number
If no, GED? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I hereby request this verification be completed and a transcript mailed to the Nursing Commission			
Signature of Applicant			Date

To be completed by the Chief Administrative Officer of the school of nursing from which the above named applicant graduated, certifying the following:

Record name of graduate _____

Name of Nursing School _____

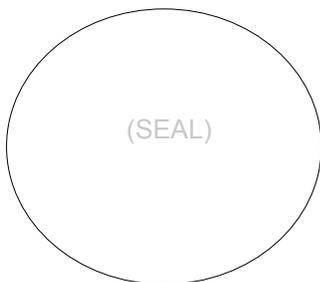
Location _____

School approved by _____ School accredited by _____

Date student entered program _____ Graduation/completion date _____

Diploma/Degree earned by Student _____

Please attach an official transcript (record of all subjects taken, including hour of class and weeks of clinical experience) for this applicant. This document must carry the school seal or stamp and signature of the chief administrator officer. **Note: Please complete both sides**



Signature _____

Title _____

Contact Email _____

Date _____

Please respond to each item listed subject matter for Licensed Practical Nurse program:
 (some subjects matter may be integrated into fundamentals of other courses)

1. Subject Matter	Completed	Not Completed
a. Physical Sciences.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Biological Sciences.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Social Sciences	<input type="checkbox"/>	<input type="checkbox"/>
d. Behavioral Sciences	<input type="checkbox"/>	<input type="checkbox"/>

2. Clinical Experience	Completed	Not Completed	Total number of clinical hours
a. Fundamentals of Nursing including Geriatric Care.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Administration of Medication.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Medical Nursing	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Surgical Nursing	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Nursing Care throughout the Lifespan.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Psychiatric/Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	_____

Return to the address listed on page 1 of this form.