



Washington State Department of
Health
 Nursing Commission
 PO Box 47864
 Olympia, WA 98504-7864
 360.236.4700

Verification of License From U.S. State of Original License

Please complete the top portion of this form and forward to your **original** state of license.
 (Please contact your original state of license for fee charged and processing time.)

Check One Box: <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical Nurse			
Name	Last	First	Middle Initial
Previous Last Names Used		Social Security Number (Required for license under 42 USC 666 and Chapter 2.23 RCW)	
Current Mailing Address			
City		State	Zip
Name as it appears on original license		Original State of Licensure	Current State of Licensure
I hereby authorize the release of my licensure data to the above address.			
Signature _____ Date _____			
This portion to be completed by original state of license and mailed to the above address.			
This is to certify that _____ was issued license number _____			
on _____ to practice <input type="checkbox"/> registered nursing <input type="checkbox"/> licensed practical nursing (vocational nursing).			
Licensed by: <input type="checkbox"/> Exam <input type="checkbox"/> Endorsement <input type="checkbox"/> Other (specify)			
Current License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed			Expiration Date
Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach explanation)			
Disciplinary action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach explanation)			
Nursing Education Program Completed:			
Location (City & State):			
Type of Nursing Program: <input type="checkbox"/> Diploma <input type="checkbox"/> BSN <input type="checkbox"/> ADN <input type="checkbox"/> LPN <input type="checkbox"/> Other (specify)			Date of Completion
Examination Scores: State Board Test Pool Exam			
(SEAL)	Score	Series	NCLEX:
	Medical	_____	RN _____ Series _____
	Psychiatric	_____	LPN _____ Series _____
	Obstetric	_____	
	Surgical	_____	NCLEX CAT:
	Nursing of Child	_____	RN _____ Date _____
LPN/VN	_____	LPN _____ Date _____	
Signature		State	Date