



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

Certificate of Completion of LPN Program **(to be completed after program completion)**

Last Name of Graduate

First Name

Middle Name/Initial

Birth date (mm/dd/yyyy)

Social Security Number

Date of Program Completion (mm/dd/yyyy)

Signature of Authorized Person

School
Seal

Title

Name of School of Nursing

Dated this _____ day of _____, 2 _____

An Official Transcript is attached or will follow as soon as possible.

Please send completed form to:

Washington Nursing Commission
PO Box 47864
Olympia, WA 98504-7864