Health Professions Quality Assurance
Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

Certificate of Completion of RN Program

(to be completed AFTER program completion)

I certify that the individual listed below **HAS** completed all requirements for the degree/diploma for the approved Registered Nurse program as outlined in WAC 246-840-575. I understand that my signature on this form will allow this individual to sit for the registered nurse licensure examination. **An official transcript with the degree/diploma posted will follow as soon as it is available.**

LAST NAME OF GRADUATE	
FIRST NAME	MIDDLE NAME/INITIAL
DATE OF BIRTH (MO/DAY/YR)	SOCIAL SECURITY NUMBER
DATE OF PROGRAM COMPLETION (MO/DAY/YR)	

____
Signature of Authorized Person

____
Title

____
Name of School of Nursing

School
Seal

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