



Nursing License Verification Form (To be completed by the licensing authority only)

Section 1: Instructions for Licensing Authority

Please provide the information requested below and return this form to Educational Perspectives, nfp:

Educational Perspectives, nfp
PO Box A3462
Chicago, IL 60690-34

Section 2: Print or Type

Name of Applicant: _____

Name of Nursing Licensing Center: _____

Address of Nursing Licensing Center: _____

Email: _____ Phone: _____ Fax: _____

Date of Issue of Nursing License: ____/____/____ Expiration of Nursing License: ____/____/____
(month/day/year) (month/day/year)

Legal Professional Title: _____

Scope of Practice: _____

Nursing License Number: _____

The License was Validated by: _____

Current Status of Nursing License: _____

If License was Restricted, Revoked, Suspended or Placed on Probation, please explain: _____

Authority that Regulated the Licensing of Nurses in Your Country at the time: _____

License Verified by

Name: _____

Title: _____

Signature: _____

Date: _____

Affix Seal Here