VERIFICATION OF LICENSE - NURSE

APPLICANT: Complete Applicant section and mail to your ORIGINAL state of license (where you took the licensing examination). **CONTACT THAT BOARD OF NURSING FOR THEIR PROCEDURES AND FEES.** If your ORIGINAL state is a member of the NURSYS System, you will need to contact them toll free at (866) 819-1700 to request a license verification form or you may download the form from their website at: **www.nursys.com**.

APPLICANT

Legal Name (First, Middle)	(Last)	Other Names Used (Include maiden name)
Address (Include Apt. No., City, State and Zip Code)		Social Security No.
		Phone No.
LICENSE NUMBER	DATE ISSUED:	Type of Registration: ☐ REGISTERED NURSE ☐ PRACTICAL NURSE

I hereby authorize the nursing licensing agency in the State of _____ to furnish to the Department of Commerce & Consumer Affairs, State of Hawaii, the information below.

SIGN HERE: _____ Date: _____

LICENSING AGENCY ONLY

This is to certify that the above-named individual was issued license number: _____

Social Security Number: _____

to practice: ☐ Registered Nursing ☐ Practical Nursing

Date of Issuance: _____

licensed by: ☐ Examination ☐ Endorsement ☐ Waiver

Current license status: ☐ Active ☐ Inactive ☐ Lapsed

Date license expires: _____

Has this license ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation)? . . . . . ☐ Yes ☐ No

If "YES", please send a copy of your board's:
1) Administrative Action
2) Final Order

EXAMINATION INFORMATION	REGISTERED NURSE (NCLEX)	REGISTERED NURSE (S.B.T.P.E.)					PRACTICAL NURSE (NCLEX or SBTPE)
		Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children	
Standard Scores							
Series/Form No.							

Number of times applicant wrote the examination?

Name of U.S. Accredited Nursing Education Program Completed (or non-U.S. Accredited Nursing Education Program approved/recognized by this State Board as equivalent to U.S. Accredited Nursing Education Program.)

Location (City and State) | Year of Graduation:

SEAL

Signature: _____

Title: _____

State: _____ Date: _____

TO THE BOARD: Return this form directly to: Hawaii Board of Nursing
P.O. Box 3469
Honolulu, HI 96801

This material can be made available for individuals with special needs. Please call (808) 586-3000 to submit your request.

Print Form

NSG-03 0511R