



Virginia Department of
Health Professions
Board of Nursing

9960 Mayland Drive
Suite 300
Perimeter Center
Henrico, Virginia 23233
(804) 367-4515
www.dhp.virginia.gov/nursing

NURSE PRACTITIONER LICENSE VERIFICATION FORM

TO THE APPLICANT – Complete the top portion only and send to the Board of Nursing in the state where you were *originally* licensed as a nurse practitioner (fee may be required).

Name: Last	First:	Middle:	Social Security Number:
------------	--------	---------	-------------------------

Address:

Nurse Practitioner License No.:

Name on Original License:	Year Issued:
---------------------------	--------------

TO THE BOARD OF NURSING: Please provide the information requested and return the form to the **Virginia Board of Nursing**
APPLICANT'S FULL NAME:

Last:	First :	Middle:	Maiden:
-------	---------	---------	---------

Name of Master's/Graduate Degree Program:	City, State or Province:	Type of Program: <input type="checkbox"/> MSN <input type="checkbox"/> Post Master's <input type="checkbox"/> Other: _____
---	--------------------------	--

Program Completion Date:	Length of Program:
--------------------------	--------------------

Master's/Graduate Degree Program Accredited/Approved By: (<i>Accrediting Authority</i>):
--

LICENSE NUMBER _____ was granted on _____ by: Examination Endorsement Waiver

Status of license: Current Lapsed Inactive

Has license ever been suspended, revoked or otherwise disciplined? Yes No . If yes, please attach certified copy of any order issued by the Board.

I *certify* the above information to be true in every respect, according to the record on file with the _____ State Board of Nursing.

SEAL

_____ Date

_____ Executive Director