Kansas State Board of Nursing
Landon State Office Building
900 SW Jackson, Ste. 1051
Topeka, KS 66612-1230
K.A.R. 60-2-103

Faculty Qualification Report (FQR)

To be submitted to KSBN by Nurse Administrator within 30 days of appointment

Name of Appointee: (name as it appears on their nursing license)

Last Name _____ First Name _____ Middle Name _____

Social Security Number: _____/___/_____

KS License #: _____ Appointment Date (mm/dd/yy): ___/___/___

Name of Program: _____

Address of Program: _____

Initial Prelicensure Preparation in Nursing*:

☐ Diploma ☐ ADN ☐ BSN ☐ Other Graduation Date ____/____
mm/yy

Name of Nursing Program: _____

City/State _____

Additional Education Obtained*:

College/University	Major	Degree Awarded		Presently Enrolled	Credits Earned
_____	_____	☐ Yes-Yr _____	☐ No	_____	_____
_____	_____	☐ Yes-Yr _____	☐ No	_____	_____
_____	_____	☐ Yes-Yr _____	☐ No	_____	_____

Type of Program: ☐ ARNP ☐ BSN ☐ ADN ☐ PN

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Adjunct

*** Include transcripts for original RN licensure degree & any further education** ☐ Degree plan included if applicable

Appointment Teaching and Clinical Responsibilities in Current:

Title of Course(s) – if not obvious, include *Clinical Specialty*	Credit Hours	Lecture	Clinical Instruction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ **Signature of Appointee**
_____ Date

_____ **Signature of Administrator**
_____ Date

Official Use Only: Transcripts: ADN DIP BS BSN MS MSN EdD DNP PhD Deg Plan Lic. Ver. Hire Exception
Lic. Exp.: _____

Date: _____ Education Specialist: _____
Carol Moreland, MSN, RN, Education Specialist