

SECTION III

KANSAS STATE BOARD OF NURSING

Landon State Office Building
900 SW Jackson, Ste 1051
Topeka, KS 66612-1230

VERIFICATION REQUEST FORM

**TO BE COMPLETED WHERE APPLICANT
WAS ORIGINALLY LICENSED**

Name: _____
Last First Middle Maiden

Address: _____
Street City State Zip

Original License Number: _____

APPLICANT – DO NOT WRITE BELOW THIS LINE

This is to certify that the above named was graduated from:

Name of School of Nursing City State

and was issued a license to practice as a _____ by _____ Examination _____ Endorsement
(PROFESSION)

Date of Graduation: _____
Month Day Year

Date of Licensure: _____
Month Day Year

Original License Number: _____

Was the nursing program state accredited/approved at the time of graduation? Yes _____ No _____

Was the State Board Test Pool Examination written? Yes _____ No _____ NCLEX? Yes _____ No _____

Has license to practice nursing ever been denied, revoked, or suspended? Yes _____ No _____
(If yes, please explain on back of form)

	Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children	NCLEX
Standard Scores	_____	_____	_____	_____	_____	_____
Series No.	_____	_____	_____	_____	_____	_____

SIGNED: _____

Title: _____

State: _____

Date: _____

(Seal of State Board
of Nursing)