EMPLOYMENT VERIFICATION FORM

SECTION I: TO BE COMPLETED BY APPLICANT/LICENSEE:

- Please note that the applicant/licensee may ONLY complete Section I
- NO correction fluid may be used on this document.

TYPE OF APPLICATION

☐ Endorsement  ☐ Reinstatement  ☐ APRN licensure  ☐ Renewal Audit

NAME OF NURSE/AUA:

My signature below authorizes the employer to complete this form & for the employer to return it directly to the Board office by mail or fax*.  
*If this form is for a renewal audit, the RN/LPN must submit with the completed audit paperwork

Signature of Nurse/AUA ________________________________ Date ________________________________

SECTION II: TO BE COMPLETED BY EMPLOYER: Please return directly to the Board office by mail or fax*

Name of Employer: ______________________________________________________________________

Address of Employer: ____________________________________________________________________

Telephone Number of Employer: ___________________________________________________________

Title of Position(s) Held by Employee: (Please attach a job description for each of the positions held.)

Position Title    Date Hired    Last Date in Position

Position Title    Date Hired    Last Date in Position

Last Date Worked in a Position Requiring a Nursing License/AUA certificate: ________________________________

Current Employment Status (i.e.: currently working, suspended, on leave, terminated, etc): ________________________________

For RN/LPN/APRN applicants only:
I certify that this nurse has worked 520 hours or more in a position requiring a nursing license in the two years immediately prior to the date of completion of this form. (Check one)

_____ Yes  _____ No (If no, please indicate the number of hours worked: ________________________________

For AUA applicants only:
I certify this AUA has worked in an acute care setting in a position requiring an AUA certificate for a minimum of 12 months within the previous 24 months

_____ Yes  If yes, please indicate the month/year employment began _____________ and month/year employment ended (if current, please indicate such) _____________

_____ No  If no, please indicate the month/year employment began _____________ and month/year employment ended (if current, please indicate such) _____________

The Oklahoma Nursing Practice Act (Oklahoma Statues 59 O.S. § 567.1 et seq.) requires that any person who represents himself/herself as a Registered Nurse, Licensed Practical Nurse or Advanced Unlicensed Assistant in this state must have a current Oklahoma license/certificate. Continued employment in nursing (including orientation to a position that requires a nursing license or AUA certificate) without a valid nursing license or AUA certificate is considered in violation of the provisions of the Oklahoma Nursing Practice Act and may subject the person to disciplinary action.

I have read the above statement. I certify that the statements contained herein are true and correct.

Signed: ___________________________________________  Date: ________________________________

Title: ___________________________________________