OKLAHOMA BOARD OF NURSING
2915 N. Classen Boulevard, Suite 524
Oklahoma City, Oklahoma 73106
Telephone: (405) 962-1800 / Fax (405) 962-1821

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, fax or e-mail***.

**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, fax or e-mail*

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 five years immediately prior to the date of completion of this form. (Check one)

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

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: _____
Title: _____ Date: _____