

**OKLAHOMA BOARD OF NURSING**  
 2915 North Classen Blvd., Suite 524  
 Oklahoma City, Oklahoma 73106  
 (405) 962-1800

**OKLAHOMA INTERSTATE VERIFICATION FORM**  
**TO BE COMPLETED BY APPLICANT AND MAILED TO ORIGINAL STATE OF LICENSURE:**

Name: \_\_\_\_\_  
                     First                    Middle                    Maiden                    Married

Mailing Address \_\_\_\_\_  
                     Street Address/Box Number                    City                    State/Zip Code

Social Security Number: \_\_\_\_\_ RN \_\_\_\_\_ LPN \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the \_\_\_\_\_ Board of Nursing  
 (signature of licensee) (State/Country of original licensure)  
 to complete the verification form below. My records are under the name of \_\_\_\_\_ and  
 license/certificate number \_\_\_\_\_.

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**TO BE COMPLETED BY THE LICENSING AGENCY IN THE STATE/COUNTRY OF ORIGINAL LICENSURE ONLY:**

This is to certify that the above named was issued certificate/license number \_\_\_\_\_

To practice: Registered Nursing \_\_\_\_\_ Date of issuance: \_\_\_\_\_  
 Practical Nursing \_\_\_\_\_

Licensed by: Examination \_\_\_\_\_ Current licensure status: Active \_\_\_\_\_  
 Endorsement \_\_\_\_\_ Inactive \_\_\_\_\_  
 Waiver \_\_\_\_\_ Lapsed \_\_\_\_\_

Date license expires \_\_\_\_\_

Has this license ever been revoked, suspended, surrendered, restricted, placed on probation, reprimanded, or currently under investigation? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, please provide information.

| Score        | SBTE/NCLEX RESULTS |       |       |       |          | NCLEX | SBTPE/NCLEX |
|--------------|--------------------|-------|-------|-------|----------|-------|-------------|
|              | Med.               | Psy.  | Obs.  | Surg. | Nsg. Ch. |       |             |
| Series       | _____              | _____ | _____ | _____ | _____    | _____ | _____       |
| Date of Exam | _____              | _____ | _____ | _____ | _____    | _____ | _____       |

Number of times applicant wrote examination: \_\_\_\_\_ If more than once, enter all dates and scores on reverse side.

Name and location of nursing program: \_\_\_\_\_

Type of Program (Check one) \_\_\_\_\_ PN \_\_\_\_\_ ADN \_\_\_\_\_ Diploma \_\_\_\_\_ BSN \_\_\_\_\_ Other

Was school state approved? Yes \_\_\_\_\_ No \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

All information above is true and accurate to the best of my knowledge:

Prepared by: \_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

State \_\_\_\_\_

Date \_\_\_\_\_

(BOARD SEAL)