

**OKLAHOMA BOARD OF NURSING**  
2501 N. Lincoln Blvd, Ste 207  
Oklahoma City, Oklahoma 73105  
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 complete ONLY Section I

**TYPE OF APPLICATION:**  Endorsement  Reinstatement  APRN licensure  Renewal Audit  Multistate OK Existing Non-Active

**NAME OF NURSE/AUA:** \_\_\_\_\_

My signature below authorizes the employer to complete this form. **The applicant is responsible for uploading this completed document to the ORBS Nurse Portal to accompany application submission.**

*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:**

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_  
Street City State

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 the nurse identified on this document 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 the AUA identified on this document 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 Statutes Title 59 §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 all the statements contained herein are true and correct.

Signed: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_