

**OKLAHOMA BOARD OF NURSING**

**2915 N. Classen Blvd., Suite 524  
Oklahoma City, Oklahoma 73106  
405/962-1800**

**FACULTY QUALIFICATION RECORD**

*A Faculty Qualification Record shall be submitted for all instructional staff (full-time, part-time, classroom, or clinical), and shall include educational preparation and employment experience [OAC 485:10-3-5(1)(A)]. The Faculty Qualification Record must be submitted to the Board office by the Nurse Administrator on a form provided by the Board within thirty days of day of appointment, a change in title or status of position, and any time an advanced degree is attained [OAC 485:10-3-5(1)(B)]. The Faculty Qualification Record may be submitted electronically to a designated email address.*

Name of Employing Nursing Program \_\_\_\_\_ City \_\_\_\_\_

Full Licensure Name \_\_\_\_\_

Oklahoma License # \_\_\_\_\_ Date of Appointment \_\_\_\_\_ Full Time (FT)  Part-Time (PT)

Title Change \_\_\_\_\_ Status Change to PT \_\_\_\_\_ to FT \_\_\_\_\_ Advanced Degree \_\_\_\_\_

Title of Position: \_\_\_\_\_ Areas of Teaching Responsibility: \_\_\_\_\_

**Educational Preparation\***

	<u>Name of School</u>	<u>City &amp; State</u>	<u>Graduation Date</u> <u>Month/Year</u>	<u>Major</u>	<u>Degree</u>
Basic Nsg. Education	_____	_____	_____	_____	_____
Advance Education	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

**\*Please attach copies of official transcripts on file at the employing institution.**

**Previous Employment\*\*** Begin with last position held. Evidence must be provided of a minimum of two (2) years full-time equivalent practice as a Registered Nurse in a clinical setting.

<u>Dates of Employment</u> <u>To/From-Month/Year)</u>	<u>Employer</u>	<u>City &amp; State</u>	<u>Position</u>	<u>FTE</u> <u>(in Years)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**\*\* These sections must be completed even if a curriculum vita and transcripts are attached to include employment in Academic setting.**

I certify that I am the faculty member who is referred to in the foregoing *Faculty Qualification Record* and that the statements therein contained are true in every respect. I certify that I have met the requirements established in the *Oklahoma Nursing Practice Act and Rules* for nursing faculty or as interim nurse administrator, including requirements for Oklahoma licensure, level of education, and clinical experience [59 O.S. §567.12(B); OAC 485:10-5-3.2(d); and OAC 485:10-5-5.2].

\_\_\_\_\_  
Signature of Faculty Member

\_\_\_\_\_  
Date

I certify that I have verified the Oklahoma nursing license of the faculty member. In addition, I have reviewed the official transcripts and work experience, and have verified that the faculty member meets the qualifications of the *Oklahoma Nursing Practice Act and Rules*.

\_\_\_\_\_  
Signature of Nurse Administrator

\_\_\_\_\_  
Date