Pasos para solicitar examen a través de NY

1. Llena la aplicación: completa sin dejar espacios en blanco. La dirección a donde enviar está abajo del documento.

2. Hacer un giro por $143 y enviar con la aplicación.

3. Llevar documento de educación a la universidad: sigue las instrucciones en el papel. Tu llenas tu secciones de información y ellos completan lo demás y la envían a la dirección provista en el documento.

4. Si tienes licencia, llevar el documento de verificación de licencia a la Junta de Enfermería. Tu llenas tus secciones de información y ellos completan lo demás y la envían a la dirección provista en el documento.

5. Tienes que completar 2 educaciones continuas obligatorias:
   - 2 horas de Child Abuse (tienes que enviar el certificado con la aplicación).
     Puedes escoger cualquiera de estos proveedores: [http://www.op.nysed.gov/training/caproviders.htm](http://www.op.nysed.gov/training/caproviders.htm)
     Tiene un costo de $30.
   - Infection Control (tienes que enviar el certificado con la aplicación).
     Puedes escoger cualquiera de estos proveedores: [http://www.op.nysed.gov/training/icproviders.htm](http://www.op.nysed.gov/training/icproviders.htm)
     Tiene un costo de $30.

Después que la Junta de NY te aprueba, recibes una carta de notificación. Una vez la recibas entonces puedes solicitar el examen a través de Pearson Vue: [http://www.pearsonvue.com/nclex/?REDIRECT_TIMESTAMP=1458767363463](http://www.pearsonvue.com/nclex/?REDIRECT_TIMESTAMP=1458767363463)

Cuando solicitas examen recuerda escoger el estado de NY, ellos te envían el código.

Si lo tomas en Estados Unidos es solo $250.
Si lo tomas en PR tienes que añadir $100.

Espero que todo esto te ayude.

Magda
## Application for Licensure

All applicants for licensure must complete this form and submit it with the appropriate licensure and registration fee ($143) directly to the Office of the Professions at the address at the end of this form. You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. You must sign and date the Affidavit on this form in the presence of a Notary Public.

### NYS License Number

<table>
<thead>
<tr>
<th>Date Issued</th>
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<tr>
<td>Initials</td>
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### Birth Date

<table>
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<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

### Social Security Number

(Leave this blank if you do not have a U.S. Social Security Number)

### Telephone/E-Mail Address

<table>
<thead>
<tr>
<th>Area Code</th>
<th>Phone Number</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>E-Mail Address</th>
<th>(Please print clearly)</th>
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### Mailing Address

<table>
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<tr>
<th>Home or Business</th>
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<th>Line 1</th>
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<th>Line 3</th>
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<table>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tr>
<th>Country/Province</th>
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### New York State DMV ID Number

<table>
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<tr>
<th>(Driver or Non-Driver ID)</th>
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</table>

(Leave this blank if you do not have a New York State DMV ID Number)

### Licensee business address, phone and e-mail address are public information. Failure to indicate business or home on this form for each item will deem it public information.

### REASONABLE TESTING ACCOMMODATIONS FOR INDIVIDUALS WITH DISABILITIES.

(Check if applicable)

### I have been diagnosed as having a disability and require special testing accommodations and am submitting the Request for Reasonable Testing Accommodations form to the address at the end of the form. I understand that I will not be able to test until I submit the appropriate documentation and am approved to test with accommodations. (See Examination Section of the Licensing Application Packet for information on obtaining the form.)

### Name as it appears on degree or other credentials (if different from above):

<table>
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<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

### Have you previously applied for New York State licensure in any profession?

| Yes | No |

### Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?

| Yes | No |

### Are criminal charges pending against you in any court?

| Yes | No |

### Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?

| Yes | No |

### Are charges pending against you in any jurisdiction for any sort of professional misconduct?

| Yes | No |

### Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?

| Yes | No |

### NOTE: If you answer “Yes” to any questions numbered 11-15, submit a letter giving a complete detailed explanation. Include copies of any court records including a Certificate of Conviction. If there are offenses in multiple courts, please provide the same for each action. If the court can no longer provide documentation, you must request, from the court, a letter stating why they cannot provide the documents.

### Name as it appears on degree or other credentials (if different from above):
Please print clearly giving an accurate record of your educational preparation below. YOU MUST COMPLETE ALL INFORMATION FOR ALL SCHOOLS/COLLEGES/UNIVERSITIES ATTENDED AND DIPLOMAS AND/OR DEGREES RECEIVED OR YOUR APPLICATION WILL BE CONSIDERED INCOMPLETE. Attach additional sheets if necessary.

Name of Elementary or Primary School:____________________________________________________________________________________
City: ____________________________________ State/Province: ____________________________ Country: ______________________________
Number of years attended: __________________________ Attendance from: ________ / ________ to ________ / ________ mo.              yr.         mo.              yr.
Completion date: ________ / ________ mo.               yr.

Name of High School/Secondary School or GED Diploma Issuer:________________________________________________________________
City: ____________________________________ State/Province: ____________________________ Country: ______________________________
Number of years attended: __________________________ Attendance from: ________ / ________ to ________ / ________ mo.              yr.         mo.              yr.
Graduation date: ________ / ________ mo.             yr.

Nursing Program:
Name of School: ___________________________________________________________________________________________________________
City: ____________________________________ State/Province: ____________________________ Country: ______________________________
Major/Concentration: ______________________________________________________________________________________________________
Number of years attended: __________________________ Attendance from: ________ / ________ to ________ / ________ mo.              yr.         mo.              yr.
Title of Degree/Diploma/Certificate awarded (in the original language): ______________________________________________ OR ☐ still in progress

Other Postsecondary Education:
1. Name of School: _______________________________________________________________________________________________________
City: ____________________________________ State/Province: ____________________________ Country: ______________________________
Major/Concentration: ______________________________________________________________________________________________________
Number of years attended: __________________________ Attendance from: ________ / ________ to ________ / ________ mo.              yr.         mo.              yr.
Title of Degree/Diploma/Certificate awarded (in the original language): _____________________________________________________________

2. Name of School: _______________________________________________________________________________________________________
City: ____________________________________ State/Province: ____________________________ Country: ______________________________
Major/Concentration: ______________________________________________________________________________________________________
Number of years attended: __________________________ Attendance from: ________ / ________ to ________ / ________ mo.              yr.         mo.              yr.
Title of Degree/Diploma/Certificate awarded (in the original language): _____________________________________________________________

*If you took the NCLEX or SBTP Examination, send Form 3 to the state in which you passed the licensing examination or request verification from Nursys.

Please print clearly giving an accurate record of your educational preparation below. YOU MUST COMPLETE ALL INFORMATION FOR ALL SCHOOLS/COLLEGES/UNIVERSITIES ATTENDED AND DIPLOMAS AND/OR DEGREES RECEIVED OR YOUR APPLICATION WILL BE CONSIDERED INCOMPLETE. Attach additional sheets if necessary.

State or Territory* | Profession(s) | SBTP, NCLEX or State-Constructed Examination | License Number, If Granted
---|---|---|---

<table>
<thead>
<tr>
<th>State or Territory*</th>
<th>Profession(s)</th>
<th>SBTP, NCLEX or State-Constructed Examination</th>
<th>License Number, If Granted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

If you have ever taken the SBTP, NCLEX, or a state-constructed examination for licensure as either a Registered Professional Nurse or a Licensed Practical Nurse in the United States or its territories (except New York State), complete the following:

Print Name exactly as you will list it on your NCLEX Examination Registration form. (This name must match the I.D. you bring to the examination.)
Last: ___________________________ First: ___________________________ Middle: ___________________________

If you have ever taken the SBTP, NCLEX, or a state-constructed examination for licensure as either a Registered Professional Nurse or a Licensed Practical Nurse in the United States or its territories (except New York State), complete the following:

<table>
<thead>
<tr>
<th>State or Territory</th>
<th>Profession(s)</th>
<th>SBTP, NCLEX or State-Constructed Examination</th>
<th>License Number, If Granted</th>
</tr>
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</table>

*If you took the NCLEX or SBTP Examination, send Form 3 to the state in which you passed the licensing examination or request verification from Nursys.
Do you now hold, or have you ever held, a license or certificate to practice any profession* in any jurisdiction?  □ Yes □ No

If yes, list each license/certificate, state or jurisdiction and provide appropriate information in the columns below. A Form 3 must be submitted for each professional license/certificate listed unless it is a license/certificate issued by the New York State Education Department. See the Applicant Instructions on Form 3 for specific information about completing and submitting the form.

*Profession is defined as professional titles licensed under New York State Education Law.

<table>
<thead>
<tr>
<th>Professional Title</th>
<th>State or Jurisdiction</th>
<th>Date License/Certificate Issued</th>
<th>License/Certificate Number</th>
<th>Limitations On License/Certificate</th>
</tr>
</thead>
</table>

CHILD SUPPORT OBLIGATION:

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support*. Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits. The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

CHECK ONLY A OR B BELOW. If you check B, you must check one of the five statements listed below it.

A  □ I am not under an obligation to pay child support:

OR

B  □ I am under an obligation to pay child support and (please check only one of the following)

  □ I am current and am not four months or more in arrears in the payment of child support: or,
  □ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
  □ The child support obligation is the subject of a pending court proceeding; or,
  □ I am receiving public assistance or supplemental security income; or,
  □ None of the above four statements apply.

*New York State General Obligations Law, section 3-503

CITIZENSHIP/IMMIGRATION STATUS

Federal law limits the issuance of professional licenses, registrations and limited permits to United States citizens or qualified aliens. To comply with this Federal law, complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

I am:

□ A. A United States citizen or National.
□ B. An alien lawfully admitted for permanent residence in the United States.
□ C. An alien granted asylum under Section 208 of the Immigration and Nationality Act.
□ D. A refugee granted asylum under Section 207 of the Immigration and Nationality Act.
□ E. An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least 1 year.
□ F. An alien whose deportation is being withheld under Section 241 (b)(3) of the Immigration and Nationality Act.
□ G. An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.
□ H. Non Immigrant (Temporarily in U.S.) Please list Visa type or immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States: _______________________________________
□ I. I do not reside in the United States.

If you checked any of the boxes from B-H, enter your alien registration number or control number issued by the United States Citizenship and Immigration Services (USCIS): ____________________________

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) BY CALLING 1-800-375-5283, OR VISIT THEIR WEB SITE AT WWW.USCIS.GOV.
CHILD ABUSE IDENTIFICATION AND REPORTING COURSEWORK REQUIREMENT — RN Applicants Only (check one):

☐ I graduated from a NYS registered nursing program after September 1, 1990 and completed the coursework during my studies.
☐ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.
☐ I completed the child abuse coursework online and the approved provider will report that to you electronically.
☐ I am filing for an exemption to the requirement and have enclosed the Certification of Exemption (Form 1CE*).

*Form 1CE is available on the Office of the Professions’ Web site at www.op.nysed.gov/documents/form1ce.pdf.

INFECTION CONTROL TRAINING REQUIREMENT (check one):

☐ I graduated from a NYS registered nursing program after September 1, 1993 and completed the infection control training during my studies.
☐ I completed the infection control training and have enclosed a certificate of completion from an approved provider.
☐ I completed the infection control training online and the approved provider will report that to you electronically.
☐ I am filing for an exemption to the requirement and have enclosed an Attestation of Infection Control Training (Form 1IC*).

*Form 1IC is available on the Office of the Professions’ Web site at www.op.nysed.gov/documents/form1ic.pdf.

EDUCATION PROGRAM REVIEW

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying the Division of Professional Licensing Services in writing.

☐ Yes  ☐ No

Please initial: __________________________

GENDER AND ETHNICITY: (This item is optional.)

Information on gender and ethnicity is sought solely to allow the New York State Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

GENDER:  ☐ Male  ☐ Female

ETHNICITY:  ☐ White (not Hispanic)  ☐ Black (not Hispanic)  ☐ Asian  ☐ Hispanic  ☐ Native American

AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

Applicant

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution. This form must be signed and dated in the presence of a Notary Public.

Applicant’s signature __________________________ Date _______ / _______ / _______  Month                Day                  Year

Notary

State of __________________________ County of __________________________

On the _______ day of __________________________ in the year _______ before me, the above signed, personally appeared __________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public’s signature __________________________

Notary ID number __________________________  Expiration date _______ / _______ / _______

Notary Stamp

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.
# CERTIFICATION OF PROFESSIONAL EDUCATION

## APPLICANT INSTRUCTIONS

1. **Do not use this form if your nursing school is located outside the United States.** (See Verifying Education Credentials from Non-U.S. Programs under Education Requirements.)

2. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 8.

3. Have the school you attended that made you eligible to take the NCLEX examination complete the appropriate parts of Section II. If you graduated from a New York State licensure qualifying nursing education program after April 1, 1998, you do not need to submit this form. Be sure to include any fee required by the school. The registrar must return the entire form in an official school envelope directly to the Office of the Professions at the address at the end of this form. This form will not be accepted if submitted by you.

## SECTION I: APPLICANT INFORMATION

<p>| | | |</p>
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<tr>
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</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Birth Date</td>
<td>Month Day Year</td>
</tr>
</tbody>
</table>

*Leave this blank if you do not have a U.S. Social Security Number*

3. Print Your Name Exactly As It Appears On Your Application for Licensure (Form 1)

   - Last
   - First
   - Middle

4. **Mailing Address** (You must notify the Department promptly of any address or name changes.)

   - Line 1
   - Line 2
   - Line 3
   - City
   - State
   - Zip Code
   - Country/Province

5. Print your name as it appears on your degree or diploma:

   ________________________________

6. Secondary institution attended:

   ________________________________

7. Nursing school attended:

   ________________________________

   Address:

   ________________________________

   Dates of attendance from __/__/__ to __/__/__

   mo. day yr. mo. day yr.

8. I request and give my permission to the school listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

   Applicant’s signature: ________________________________ Date: __/__/__

   mo. day yr.
(1) Name of applicant ____________________________________________________________ (see Section I, item 5)

(2) Nursing school name: ____________________________________________________________

Address: __________________________________________________________________________ (Street)

________________________________________________________________________________ (City) (State) (Zip Code) (Country)

(3) Is this program located In the United States or its territories? (check one) ☐ Yes ☐ No

If no, do not use this form. If Yes, complete the remainder of this form.

(4) Date on which faculty approved the awarding of the degree or diploma or date degree awarded: _______ / _______ / _______

(5) This program was approved as preparing for licensure as a Registered Professional Nurse or Licensed Practical Nurse by:

________________________________________________________________________________ (Name of state or U.S. territory)

(6) Type of program: ☐ Baccalaureate ☐ Diploma ☐ Associate ☐ Other ________________________________

(7) Title of degree awarded: __________________________________________________________

CERTIFICATION

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.

Signature of Registrar _________________________________________________________ Date _______ / _______ / _______

Print Name ______________________________________________________________________

Title or official position ____________________________________________________________

Institution ______________________________________________________________________

Address ______________________________________________________________________

________________________________________________________________________________

Telephone __________________________ Fax ____________________________

INSTITUTION SEAL

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Unit, 89 Washington Avenue, Albany, NY 12234-1000.
**Nurse Form 3 (Check one)**

- [ ] Registered Professional Nurse
- [ ] Licensed Practical Nurse

---

**VERIFICATION OF OTHER PROFESSIONAL LICENSURE/CERTIFICATION**

(Complete this form if you hold, or have ever held, a license or certificate to practice any profession* in any jurisdiction)

*Profession is defined as professional titles licensed under New York State Education Law (see page 2 of the Address/Name Change Form).

---

**APPLICANT INSTRUCTIONS**

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 9.
2. Send the entire form to the appropriate licensing/certifying authority for completion of Section II. Be sure to include any fee required by that licensing/certifying authority. We must receive a Form 3 for all professional licenses/certificates you ever held except those issued by the New York State Education Department. This form will not be accepted if submitted by you.

---

### Section I: Applicant Information

1. **Social Security Number**
   - [ ] [ ] [ ] [ ] [ ] [ ] [ ]

2. **Birth Date**
   - [ ] [ ] [ ]

   (Leave this blank if you do not have a U.S. Social Security Number)

3. **Print Your Name Exactly As It Appears On Your Application for Licensure (Form 1)**
   - Last
   - First
   - Middle

4. **Mailing Address** (You must notify the Department promptly of any address or name changes.)
   - Line 1
   - Line 2
   - Line 3
   - City
   - State [ ] Zip Code [ ]
   - Country/Province

5. **Licensing/certifying authority to which this form is being sent:**
   - Print name of licensing/certifying authority

6. **If you were issued a license/certificate by this licensing/certifying authority, print your name as it appears on your license/certificate.**
   - Print name
   - Professional title on license/certificate issued:

7. **If you took a licensing examination in the United States using a different name, enter that name below:**
   - Last
   - First
   - Middle

8. **If licensed/certified as a nurse, name of school of nursing:**
   - Address:
   - Date certificate or diploma in nursing was awarded or is expected to be awarded: [ ] [ ] [ ]

9. **I request and give my permission to the licensing/certifying authority listed in item 5 above to complete the information on this form and mail it to the New York State Education Department and to release any other information required by the State Education Department in connection with my application for licensure. I also declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.**
   - Applicant’s signature:
   - Date: [ ] [ ] [ ]

---

Nurse Form 3, Page 1 of 2, Rev. 1/13
INSTRUCTIONS TO THE LICENSING/CERTIFYING AUTHORITY: Please complete items 1-4, sign and date the certification and return both pages of this form in an official envelope directly to the Office of the Professions at the address below. This form will not be accepted if returned by the applicant. Attach additional sheets if necessary.

1. Name of applicant: ____________________________________________________________

2. Professional title on license/certificate: ____________________________________________________________________________________
   License/certificate number: ___________________________________________
   Date of licensure/certification: ________ / ________ / ________

3. Verification of licensure/certification – Complete if applicant was licensed/certified as a nurse or was approved to take the State Board Test Pool (SBTP) or the National Council Licensing Examination (NCLEX) in your jurisdiction.
   A. The nursing program indicated in item 8 on page 1 was:
      1. approved by this licensing authority at the time of the applicant’s attendance. □ Yes □ No
      2. approved by this licensing authority at the time of the applicant’s graduation. □ Yes □ No
      3. either a practical nursing program of at least nine months in length; or was a professional registered nursing program of at least two year duration. □ Yes □ No
   B. Basis of licensure (check one): □ Examination □ Waiver of Examination □ Endorsement □ Waiver of Education Requirement
   C. Did issuing this license involve any special conditions? □ Yes □ No
   D. Certification of Examination Results (attach additional sheets if necessary)

<table>
<thead>
<tr>
<th>Exam Date</th>
<th>Series Number</th>
<th>NCLEX Exam</th>
<th>OR</th>
<th>STATE BOARD TEST POOL EXAM SCORES</th>
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<td>Medical Nursing</td>
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<td>Psychiatric Nursing</td>
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<td>Obstetric Nursing</td>
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<td>Surgical Nursing</td>
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<td></td>
<td>Pediatric Nursing</td>
</tr>
</tbody>
</table>

4. Complete if applicant was issued a license/certificate by your jurisdiction.
   A. Has disciplinary action been taken against this license? □ Yes □ No
   B. Are disciplinary charges pending against this license? □ Yes □ No
   If the answer to either of these questions is “yes”, please attach a complete explanation with any supporting documentation.

Certification
I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form. I further certify that, except as noted in item 4 above or in any attachments, this licensing/certifying authority has never taken any disciplinary action against this person and that in so far as the licensing/certifying authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct.

Signature: ________________________________ Date: _______ / _______ / _______
Print name: ____________________________________________________________________
Title: _______________________________________________________________________
Licensing/certifying authority: ___________________________________________________
Address: ________________________________________________________________ (SEAL)
City: ____________________________ State ___________ Zip Code ____________________
Telephone: _______________________________ Fax: ________________________________
E-mail Address: _______________________________________________________________

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Unit, 89 Washington Avenue, Albany, NY 12234-1000.