



Oregon State Board of Nursing

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Nursing Practice History

Please type or print clearly using black ink on the front and back

- If you worked for a multi-state corporation or agency, list location of your assignment(s), not the state where the corporate headquarters is located.
- List your nursing practice history, for the most recent five years in which you practiced nursing.
- Complete a separate section for each nursing position in the last or most recent five years.
- If you volunteered or did private duty, give the name and address of the registry or individual.

Mark here if you are a recent Nursing graduate and do not have any Nursing practice history.

Last Name	First Name	Social Security Number
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Indicate your practice hours by **calendar year for the most recent six years** you have practiced. (Do not include hours you were on vacation, sick leave or leave of absence.) For example, if you last practiced in 2005, complete the Practice Summary Table for years 2005, 2004, 2003, 2002, 2001 and 2000.

Practice Summary Table	Calendar Year Practiced	Total Hours Practiced Each Year	Nursing License(s) Used for Practice
1 st year (most recent)			
2 nd year			
3 rd year			
4 th year			
5 th year			
6 th year			

Most recent employer – Not agency (If none, indicate NONE)	Area Code ()	Telephone Number
Employer Address	City	State Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice		
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)		
Position Held	Primary Duties as a Nurse (Describe briefly)	

Employer Name – Not agency (If none, indicate NONE)	Area Code ()	Telephone Number
Employer Address	City	State Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice		
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)		
Position Held	Primary Duties as a Nurse (Describe briefly)	

Employer Name – Not agency (If none, indicate NONE)	Area Code ()	Telephone Number
Employer Address	City	State Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice		
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)		
Position Held	Primary Duties as a Nurse (Describe briefly)	

Employer Name – Not agency (If none, indicate NONE)	Area Code ()	Telephone Number
Employer Address	City	State Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice		
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)		
Position Held	Primary Duties as a Nurse (Describe briefly)	

Employer Name – Not agency (If none, indicate NONE)	Area Code ()	Telephone Number
Employer Address	City	State Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice		
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)		
Position Held	Primary Duties as a Nurse (Describe briefly)	