



Oregon State Board of Nursing
 17938 SW Upper Boones Ferry Rd.
 Portland, OR 97224-7012
 971-673-0685
 www.oregon.gov/OSBN

Oregon State Board of Nursing LPN/RN Original State License Verification

APPLICANT: Use this form for verification of your initial state license that you received after successfully passing the NCLEX/SBTPE exam, **AND** only if that state/US jurisdiction does not participate in NURSYS for *license verification purposes*. Fill out Section 1 of this form and sign and date it. Leave Section 2 blank. Send the form directly to the state nursing board to complete the requested information in Section 2.

Section 1: Contact and Address Information - FILLED OUT BY APPLICANT.

Last Name:		First Name:	
Middle Name:		Former Name(s):	
Mailing Address:		Date of Birth: (mm/dd/yy)	
City:	State:	Zip:	Email:
I authorize the release of information requested below to the Oregon State Board of Nursing.			
Signature:		Date:	

Section 2: License Verification RN LPN

NURSING BOARD STAFF: Please provide the following information. Sign, affix seal/stamp, and mail directly to OSBN at the address listed at the top of the form.

State/US Jurisdiction:		Name of Licensing Agency:	
Licensing Exam: <input type="checkbox"/> NCLEX <input type="checkbox"/> SBTPE	Passing Exam Date:		Original Issue Date:
	Combined Score:		
License Number:		Expiration Date:	
Licensure Status: <input type="checkbox"/> Active <input type="checkbox"/> Encumbered <input type="checkbox"/> Expired <input type="checkbox"/> Lapsed		License Discipline: include documentation if applicable. <input type="checkbox"/> NONE <input type="checkbox"/> Revocation <input type="checkbox"/> Voluntary Surrender <input type="checkbox"/> Probation <input type="checkbox"/> Suspension	
Name of Nursing School:			City, State/Province, Country:
Degree Received: <input type="checkbox"/> Practical Nurse Certificate <input type="checkbox"/> Associates in Nursing <input type="checkbox"/> Masters in Nursing <input type="checkbox"/> RN Nursing Diploma <input type="checkbox"/> Bachelors in Nursing <input type="checkbox"/> Doctorate in Nursing			Graduation Date:
Board Seal	I verify the above information is true and correct as recorded by our office.		
	Signature: _____		
	Printed Name: _____		
	Title: _____		
	Date (mm/dd/yy): _____		