



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
**BOARD OF NURSING**

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: [DPR.DELAWARE.GOV](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@delaware.gov](mailto:customerservice.dpr@delaware.gov)

**NURSING AUDIT VERIFICATION OF PRACTICE/EMPLOYMENT  
ATTN: DELAWARE BOARD OF NURSING**

**THIS SECTION TO BE COMPLETED BY LICENSEE**

Name of Licensee: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Nursing License Number: \_\_\_\_\_ License Expiration Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

As a nurse licensed in the State of Delaware, I authorize release of employment title and dates of employment to the Delaware Board of Nursing.

**Nurse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY EMPLOYER**

**This verification is needed for audit of the Delaware Nursing license shown above. Nursing Board office must receive completed form directly from employer. Form must be received no later than July 1.**

Supervisor's Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Please Print

Firm/Company Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone: \_\_\_\_\_ Employee's Job Title: \_\_\_\_\_

Employment Dates: From: \_\_\_\_\_ To: \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Full Time  Part Time  Average Number Hours Per Week: \_\_\_\_\_

**Supervisor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employer/Supervisor – Email this form to:**

[customerservice.dpr@delaware.gov](mailto:customerservice.dpr@delaware.gov)

**Email ONLY**

**DO NOT FAX OR MAIL**