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
EMAIL: customerservice.dpr@delaware.gov

VERIFICATION OF NATIONAL CERTIFICATION FOR ADVANCED PRACTICE REGISTERED NURSES

APPLICANT INFORMATION - to be completed by APRN applicant

ENTER YOUR APPLICATION ID:_____

Send to the national certifying organization for your advanced practice specialty.

1. Name: _____ _____ _____ Social Security Number: _____
   Last First Middle
2. Address:_____
   Street
   _____ _____ _____
   City State Zip
3. Phone: _____ Email: _____

As an applicant for APRN licensure in the State of Delaware, I authorize release of the requested information.

Applicant Signature: _____ Date: _____

CERTIFICATION – to be completed by national certifying organization

Return completed form *directly* to Board office address above.

1. Name of School/Program Applicant Attended: _____
2. Address:_____
   Street
   _____ _____ _____
   City State Zip
3. Entered Program (month/year): _____ Completed (month/year): _____
4. Was school/program approved? Yes ☐ No ☐ If yes, by what certifying body? _____
5. Was program an external degree? Yes ☐ No ☐
6. Type of Program: Certificate ☐ Baccalaureate ☐ MSN ☐ Area of Specialty: _____
7. Certification No.: _____ Effective Date: ☐ Exam _____ ☐ Waiver _____
   month/day/year month/day/year
8. Certificate Status: ☐ Active/Current _____ ☐ Lapsed/Delinquent _____ ☐ Inactive/Non-Practicing
   month/day/year month/day/year
9. Has disciplinary action been taken against this certificate ***or*** has it ever been voluntarily surrendered? Yes ☐ No ☐
   If yes, please explain on a separate sheet.

I certify that the information above is a true report for the nurse named above according to this agency's records.

Certifying Agency: _____

Person Completing Form: _____ Title:_____

SEAL

Signature: _____ Date:_____