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 ORIGINAL LICENSURE

SECTION A: **APPLICANT INFORMATION – to be completed by applicant**
ENTER YOUR APPLICATION ID:_____

Use this form only if the state or other jurisdiction where you were originally licensed by examination is ***not*** listed below. If your original jurisdiction ***is*** listed below, go to https://www.nursys.com/ and submit the *Nursys Verification Request*.

Alaska, Alabama, American Samoa, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana-Registered Nurse, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Northern Mariana Islands, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virgin Islands, Virginia, Washington, West Virginia, Wisconsin, Wyoming

Mail form to jurisdiction where you were originally licensed by examination. Find out if the jurisdiction requires a fee before mailing.

1. State/Jurisdiction Where Originally Licensed: _____ 2. License Number: _____

3. Name: _____ _____ _____
Last First Middle
If originally licensed under another name, enclose copy of legal document showing name change.

4. Address:_____
Street
_____ _____ _____
City State Zip

5. Social Security Number: _____

SECTION B: **ORIGINAL LICENSURE VERIFICATION – to be completed by Board of Nursing in jurisdiction of original licensure – return to Delaware Board of Nursing at address above**

Name of Nursing School: _____ Board-Approved? Yes ☐ No ☐

Location: _____ Year Graduated: _____

Program: AD ☐ BSN ☐ Diploma ☐ PN ☐ High School Graduate or GED? Yes ☐ No ☐

NCLEX/CAT: Series: _____ Date: _____ Pass: _____

SBTPE Series: _____ Date: _____ Med:_____ OB: _____ Surg: _____ Peds: _____ PSV: _____

Date of Original Licensure: _____ License Number: _____ Expiration Date: _____

Currently licensed? Yes ☐ No ☐

Has license ever been disciplined? Yes ☐ No ☐ If yes, enclose copy of "decision & order" for each action.

I certify that the statements contained herein are true to the best of my knowledge.

Board Representative Signature: _____ Date: _____

Title: _____

State/Commonwealth of _____ Board of Nursing

BOARD SEAL