Nurse Form 3
Verification of Other Professional Licensure/Certification

The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Complete this form if you hold, or have ever held, a license or certificate to practice any profession* in any jurisdiction
*Profession is defined as professional titles licensed under New York State Education Law (see page 2 of the Address/Name Change Form).

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 10.
2. Send the entire form to the appropriate licensing/certifying authority for completion of Section II. Be sure to include any fee required by that licensing/certifying authority. We must receive a Form 3 for all professional licenses/certificates you ever held except those issued by the New York State Education Department. **This form will not be accepted if submitted by you**.

Section I - Applicant Information

1. Check what you are applying for ☐ Registered Professional Nurse ☐ Licensed Practical Nurse

2. Social Security Number _____ 3. Birth Date Month ____ Day ____ Year ____
(Leave this blank if you do not have a U.S. Social Security Number)

4. Print Your Name Exactly As It Appears On Your Application for Licensure (Form 1)

Last _____
First _____
Middle _____

5. Mailing Address (You must notify the Department promptly of any address or name changes)

Line 1 _____
Line 2 _____
Line 3 _____
City _____
State ____ ZIP Code _____ _____
Country/ Province _____

6. Name of licensing/certifying authority to which this form is being sent _____

7. If you were issued a license/certificate by this licensing/certifying authority, print your name as it appears on your license/certificate

Print name _____

Professional title on license/certificate issued _____

8. If you took the NCLEX or another United States licensing examination using a different name, enter that name below

Last _____ First _____ Middle _____

9. If licensed/certified as a nurse, name of school of nursing _____

Address _____

Date certificate or diploma in nursing was awarded or is expected to be awarded ____ ____ ____
mo. day yr.

10. I request and give my permission to the licensing/certifying authority listed in item 6 above to complete the information on this form and mail it to the New York State Education Department and to release any other information required by the State Education Department in connection with my application for licensure. I also declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

_____ _____
Applicant's Signature Date

Section II - Verification of Licensure/Certification (Please print or type)

Instructions to the Licensing/Certifying Authority: Please complete items 1-4, sign and date the certification and return both pages of this form in an official envelope directly to the Office of the Professions at the address below. **This form will not be accepted if returned by the applicant.** Attach additional sheets if necessary.

1. Name of the applicant _____
(see Section I, item 7)

2. Professional title on license/certificate _____

License/certificate number _____ Date of licensure/certification ____ ____ ____
mo. day yr.

3. Verification of licensure/certification - Complete if applicant was licensed/certified as a nurse or was approved to take the State Board Test Pool (SBTP) or the National Council Licensing Examination (NCLEX) in your jurisdiction.

A. The nursing program indicated in item 9 on page 1 was:
1. approved by this licensing authority at the time of the applicant's attendance. ☐ Yes ☐ No
2. approved by this licensing authority at the time of the applicant's graduation. ☐ Yes ☐ No
3. either a practical nursing program of at least nine months in length; or was a professional registered nursing program or of at least two-year duration. ☐ Yes ☐ No

B. Basis of licensure (check one): ☐ Examination ☐ Waiver of Examination ☐ Endorsement ☐ Waiver of Education Requirement

C. Did issuing this license involve any special conditions? ☐ Yes ☐ No

D. Certification of Examination Results (attach additional sheets if necessary)

Exam Date	Series Number	NCLEX Exam	Or	State Board Test Pool Exam Scores			
		NCLEX Exam Score		Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Pediatric Nursing

Licensed Practical Nursing - Examination scores and dates

Exam Date	Series Number	Exam		Exam Score
		NCLEX (check box)	Other Series (Specify)	
		☐		
		☐		
		☐		

4. Complete if applicant was issued a license/certificate by your jurisdiction.

A. Has disciplinary action been taken against this license? ☐ Yes ☐ No

B. Are disciplinary charges pending against this license? ☐ Yes ☐ No

If the answer to either of these questions is "yes", please attach a complete explanation with any supporting documentation

Certification

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form. I further certify that, except as noted in item 4 above or in any attachments, this licensing/certifying authority has never taken any disciplinary action against this person and that in so far as the licensing/certifying authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct.

Signature _____ Date _____

Print Name _____

Title _____

License/certifying authority _____ Seal

Address _____

Telephone _____ Fax _____

Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Unit, 89 Washington Avenue, Albany, NY 12234-1000, U.S.A.. **OR, Submit this form to the Department by E-mail at DPLSVerif@nysed.gov.**

Reset Form