



Verification of Original Licensure

* Most States Charge A Fee to Verify Your Board Scores

Maryland Board of Nursing
4140 Patterson Avenue
Baltimore, MD 21215-2254
410-585-1900

A P P L I C A N T	PART 1: To be completed by the applicant and forwarded to original state of licensure and all appropriate licensing boards.					
	Name (Last, First, Middle, Maiden)			Previous Name(s)		
	Current Street Address			City	State	Zip
	Date of Birth (MM/DD/YYYY)		Social Security Number		Nursing Education Program	
	Degree Granted					
	Name as it appears on original license (Last, First, Middle, Maiden)			City of Program		State
	Date of Completion					
	Original State of Licensure		Issue Date of Original License		Original License #	
	Type of License <input type="checkbox"/> RN <input type="checkbox"/> LP/VN					
	Current State of Licensure		Issue Date of Current License		Current License #	
Type of License <input type="checkbox"/> RN <input type="checkbox"/> LP/VN						
LIST ALL OTHER STATES OF LICENSURE			I hereby authorize all identified Boards of Nursing to release my licensure data to the Maryland Board of Nursing			
State: _____ License Number: _____ Date Issued: _____			Signature: _____			
State: _____ License Number: _____ Date Issued: _____			Date: _____			
State: _____ License Number: _____ Date Issued: _____						
State: _____ License Number: _____ Date Issued: _____						

L I C E N S E B O A R D	PART 2: To be completed by licensing board and forwarded to the Maryland Board of Nursing.					
	This is to certify that _____ was issued License number _____ Date Issued: _____					
	(Applicant Name) to practice <input type="checkbox"/> Registered Nursing					
	<input type="checkbox"/> Practical/Vocational Nursing					
Licensed by: <input type="checkbox"/> Examination		Current License Status: <input type="checkbox"/> Active				
<input type="checkbox"/> Endorsement		<input type="checkbox"/> Inactive				
<input type="checkbox"/> Waiver		<input type="checkbox"/> Lapsed				
Expiration Date: _____						
Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, or placed on probation)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Disciplinary action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain YES responses on reverse side.						

O R I G I N A L L I C E N S E B O A R D	Part 3: To be completed only by original state of licensure and forwarded to the Maryland Board of Nursing.					
	Nursing Education Program Completed		Approved by State? <input type="checkbox"/> Yes <input type="checkbox"/> No		Graduated from : <input type="checkbox"/> H.S. <input type="checkbox"/> H.S. Equivalency <input type="checkbox"/> 10 th Grade	
	Location (city/state)		Graduation Date		Type of Nursing Program <input type="checkbox"/> DIP <input type="checkbox"/> AD <input type="checkbox"/> BSN <input type="checkbox"/> LPN	
	STATE BOARD TEST POOL EXAMINATION					
	Registered Nurse					
		Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children
Score		Number of times applicant wrote exam		Dates: _____		
<input type="checkbox"/> State/Provincial Constructed Exam _____		Exam in English? <input type="checkbox"/> Yes <input type="checkbox"/> No		_____		
<input type="checkbox"/> CNATS Exam _____		Took CGFNS? <input type="checkbox"/> Yes <input type="checkbox"/> No		_____		
<input type="checkbox"/> Other (please explain) _____				_____		

SEAL

Signature _____
Title _____
State _____ Date _____