

Complete verifications must be mailed directly from the verifying agency to:

Board of Nursing

4052 Bald Cypress Way Bin C-02
Tallahassee, FL 32399-3252



Board of Nursing Employment Verification Request

Who needs to use this form?

- Applicants who **have not** taken the NCLEX but have practiced in a U.S. state or territory must show proof of work in a U.S. state or territory for two of the last three years at the level (LPN/RN) of licensure as it relates to the selected application type.
- Applicants who have taken the SBTPE or NCLEX, but **do not have** an active license, and who have worked in the previous five years.

Applicants who have taken the SBTPE or NCLEX and have an active license **DO NOT** need to complete this form.

Part I: To be completed by applicant (Complete this section and submit a copy to each place you were employed as a nurse at the level you are applying for during the last three years.)

Name: _____

Address: _____

Name of hospital or agency: _____

I hereby authorize release of any information regarding my employment status with your facility to the Florida Board of Nursing.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by employer- All verifications must be in English and mailed directly from the hospital personnel office or agency/employer and must include the following:

- * Typed on official agency letterhead with an original signature
- * Applicant name
- * Applicant's Social Security Number
- * Indicate level of licensure while employed (Registered Nurse/Licensed Practical Nurse)
- * Position title while employed
- * Place of employment
- * Address of employer (including mailing address, city, state, ZIP, country)
- * Employer's telephone number (including area code)
- * Start and end dates of employment (month and year)
- * Eligible for rehire? (Yes/No) If not eligible for rehire, please provide written details
- * Printed name of verifying agent
- * Signature of verifying agent and date completed