State Board of Nursing
2525 N 7th Street
Harrisburg PA 17110

State Board of Nursing
P O BOX 2649
Harrisburg PA 17105-2649

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

VERIFICATION OF CLINICAL NURSE SPECIALIST EDUCATION PROGRAM

APPLICANT INFORMATION

NAME:	Last	First	Middle
OTHER NAME(S):			
DATE OF BIRTH :		**LAST 4 DIGITS OF SSN:**	
ADDRESS:			
CITY / STATE / ZIP:			

FULL NAME OF COLLEGE/UNIVERSITY:			
ADDRESS (city and state):			
DATE OF PROGRAM COMPLETION :		**DEGREE AWARDED :**	
CLINICAL NURSE SPECIALIST PROGRAM SPECIALTY:		**PROGRAM ACCREDITATION:**	
DID COMPLETION OF THIS PROGRAM MAKE THE GRADUATE ELIGIBLE TO TAKE A CNS NATIONAL CERTIFICATION EXAM?			
IF YES: NATIONAL CERTIFICATION OGANIZATION:		**SPECIALTY:**	

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DIRECTOR/DEAN/REGISTRAR:			
DATE :	Month	Day	Year

(Seal of School)

RETURN <u>DIRECTLY</u> TO THE PENNSYLVANIA STATE BOARD OF NURSING IN AN OFFICIAL SCHOOL ENVELOPE TO THIS ADDRESS:

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