State Board of Nursing

2525 N 7th Street

Harrisburg, PA 17110

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

State Board of Nursing

P O BOX 2649

Harrisburg PA 17105-2649

VERIFICATION OF NURSE PRACTITIONER PROGRAM

APPLICANT INFORMATION

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

TO BE COMPLETED BY THE NURSE PRACTITIONER PROGRAM DIRECTOR ONLY

NAME OF PROGRAM:					
CITY / STATE:					
PRINT NAME OF DIRECTOR:					
DIRECTOR'S PHONE NUMBER:					
DIRECTOR'S EMAIL ADDRESS:					
PROGRAM SPECIALTY:		**DATE OF PROGRAM COMPLETION:**		**DEGREE AWARDED:**	

Completed at least 45 hours / 3 credits of ADVANCED PHARMACOLOGY as part of the Nurse Practitioner Program. Yes ____ No ____

This Program included 2 hours of education in pain management or the identification of addiction. Yes ____ No ____

This Program included 2 hours of education in the practices of prescribing or dispensing of opioids. Yes ____ No ____

Advanced Pharmacology Completion Date: Month_____ Day_____ Year_____

*To be Completed by **Out-of-State** Nurse Practitioner Program Directors Only:*

*Total number of clinical hours completed:		*Length of Nurse Practitioner Program:	
*Program Accreditation: CCNE _____ ACEN _____			
*List Course Numbers for corresponding content:			
*** CONTENT TYPE**	**COURSE NUMBER**	**CONTENT TYPE**	**COURSE NUMBER**
*Theoretical foundations of nursing practice:		*Professional role development:	
*Human diversity/social issues:		*Health promotion / disease prevention:	
*Health care policy / organization:		*Research:	
*Advanced health / physical assessment:		*Ethics:	
*Advanced physiology / pathophysiology:		*Advanced Pharmacology:	

I verify that the above statements are true and correct as validated by my review of the applicant's school records. I verify that the information communicated on this form is true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsification to authorities.

Original Signature of Director:		DATE:	Month:	Day:	Year:

(School Seal)

RETURN THIS FORM TO THE STATE BOARD OF NURSING
VIA MAIL: PO BOX 2649, HARRISBURG, PA 17105
OR EMAIL: ST-NURSE@PA.GOV.