BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | F (916) 574-8637 | www.rn.ca.gov

INTERNATIONAL LICENSE VERIFICATION

Send this form to the licensing regulatory agency where you were licensed.

PART I: To be completed by APPLICANT and forwarded to appropriate licensing agency.

Name: *(Last, First, Middle)*			**Previous Names:** *(Including Maiden)*
Current Street Address of Record:			
City:	**Province or State:**	**Country:**	**Postal Code or Zip:**
Name as it Appeared on Original License: *(Last, First, Middle)*		**Date of Birth:** *(Month/Day/Year)*	
Country of Original Licensure:	**Issue Date of License:**	**License/Diploma Number:**	
Name of School:	**Graduation Date:**	**Type of Nursing Program:** ☐ **DIP** ☐ **BSN** ☐ **MSN** ☐ **Other**	
Address of School:			
(City)	**(Province or State)**	**(Country)**	**(Postal Code)**

I hereby authorize all identified Licensing agencies to release my licensure data to the California Board of Registered Nursing.

Signature: ____ **Date:** ____________________

PART II: To be completed by licensing agency and sent to the California Board of Nursing listed at the top of this form.

This is to certify that this applicant was issued a license and/or diploma number to practice as a registered nurse:

Applicant Name: ______________________________ **License/Diploma Number:** ________________

Date License/Diploma Issued: ______________________ **Expiration Date:** ________________________

Type of License: General Nurse ☐ **Midwife** ☐ **Public Health** ☐ **Psychiatric** ☐ **Other** ☐ **please list:** ________________________	**License/Diploma Number of other license:**
Examination Taken: National ☐ State ☐ Other________________________ Exam Covered: Medical ☐ Surgical ☐ Pediatric ☐ Obstetric ☐ Psychiatric ☐	**Language Examination Taken:** ☐ **English** ☐ **Other** __________________

Signature: ____ **Title:** ____________________________

Licensing Agency: ____ **Date:** __________________________

Agency Address: ____

[COUNTRY SEAL] **FILE NO.** ____________________

(01/08/19)