**OKLAHOMA BOARD OF NURSING**
2915 N. Classen Boulevard, Suite 524
Oklahoma City, Oklahoma 73106
Telephone: (405) 962-1800 / Fax (405) 962-1821

## EMPLOYMENT VERIFICATION FORM

**SECTION I: TO BE COMPLETED BY APPLICANT**:

- Please note that the applicant may not complete any part of this form, with the exception of "Name of Nurse/AUA".
- No correction fluid may be used on this document.

TYPE OF APPLICATION ☐ Endorsement ☐ Reinstatement ☐ APRN licensure

NAME OF NURSE/AUA: _____

The signature below authorizes the employer to complete this form and **return it directly to the Board office by mail or fax**.

_____ _____
Signature of Nurse/AUA Date

**SECTION II: TO BE COMPLETED BY EMPLOYER**:

Name of Employer: _____

Address of Employer: _____

Telephone Number of Employer: _____

Title of Position(s) Held by Employee: **(Please attach a job description for each of the positions held.)**

_____
Position Title Date Hired Last Date in Position

_____
Position Title Date Hired Last Date in Position

_____
Position Title Date Hired Last Date in Position

Last Date Worked in a Position Requiring a Nursing License/AUA certificate: _____

Current Employment Status (i.e.: currently working, suspended, on leave, terminated, etc): _____

**I certify that this nurse/AUA has worked 520 hours or more in a position requiring a nursing license/AUA certificate in the two years immediately prior to the date of completion of this form**. (Check one)

_____ Yes
_____ No (If no, please indicate the number of hours worked: _____ Hours)

**The *Oklahoma Nursing Practice Act* (Oklahoma Statues 59 O.S. § 567.1 et seq.) requires that any person who represents himself/herself as a Registered Nurse, Licensed Practical Nurse or Advanced Unlicensed Assistant in this state must have a current Oklahoma license/certificate. Continued employment in nursing (including orientation to a position that requires a nursing license or AUA certificate) without a valid nursing license or AUA certificate is considered in violation of the provisions of the *Oklahoma Nursing Practice Act* and may subject the person to disciplinary action.**

I have read the above statement. I certify that the statements contained herein are true and correct.

Signed: _____
Title: _____
Date: _____