

# Louisiana State Board of Nursing

Telephone: (225) 755-7500 or (225) 755-7520  
Website: [www.lsbn.state.la.us](http://www.lsbn.state.la.us) Email: [renewals@lsbn.state.la.us](mailto:renewals@lsbn.state.la.us)

## CE/NURSING PRACTICE AUDIT FORM # 2- RN NURSING EMPLOYMENT VERIFICATION

### INSTRUCTIONS FOR RN SELECTED FOR AUDIT:

If you indicated either option # 1 or # 3E on the '[CE/Nursing Practice Audit Form # 1 – RN Audit Attestation](#)', this form **must** be completed and signed by your nursing employer(s) and mailed **by you** to LSBN along with all required audit documents in one envelope. This form must be completed/signed by personnel authorized by the employer such as the: DON, CNO, Charge Nurse, RN Supervisor, HR Department or Payroll Department. The employer(s) **must** provide employment dates. If you worked less than 900 hours with an employer, the employer **must** also provide the total number of hours you worked as an RN during the 2-year licensure period. *It is the RN's responsibility to obtain this completed/signed form in sufficient time to include with all required audit documents which must be **RECEIVED at the LSBN office no later than the date/deadline** in the correspondence notifying you that you were selected for the audit.* Read each question & answer on the '[CE Audit FAQs](#)' carefully prior to submitting all required audit documents in one envelope to LSBN.

**Mail this form and all other audit documentation to LSBN ATTN: CE/Nursing Practice Audit in one (1) envelope.** If you wish to confirm that documents are received in the LSBN office, send mail to LSBN using a delivery service that provides you with a tracking number.

### INSTRUCTIONS FOR NURSING EMPLOYER:

The RN providing this form to you has been selected for audit of his/her nursing CE/nursing practice by LSBN and must provide this form, completed and signed by an authorized representative with your company. Please complete and sign this form clearly indicating the hours the RN worked for your company **during the 2-year licensure period**. Include the RN's initial hire date in the space marked "From" and last date he/she worked in the "To" space below. Write "Present" if still employed.

*Please return this completed form directly to the RN as soon as possible.*

**Do NOT mail or fax this form to LSBN. The audited RN must submit required documents, including this form, to LSBN.**

If the RN worked fewer than 900 hours during the 2-year licensure period, check the '0-899 hour' level and write the total number of hours he/she worked for your company during the 2-year licensure period in the space provided.

Please clearly **PRINT** and provide **all** contact information requested in case LSBN needs to contact you for verification.

This is to certify that \_\_\_\_\_ is/was employed as a

Please PRINT RN's name above

**Registered Nurse (RN) at the facility named below, practiced in a competent and safe manner within the scope of an RN and completed (select one):**

- 900 hours or more of nursing practice within the preceding 2-year period
- 0 to 899 hours of nursing practice within the preceding 2-year period → Total hours worked: \_\_\_\_\_

**Provide RN's employment dates below:**

**From:** \_\_\_\_\_  
Original hire date: Month/Day/Year format

**To:** \_\_\_\_\_  
Provide last day nurse worked: Month/Day/Year

**Name of Hospital/Agency:** \_\_\_\_\_

**Department/Unit:** \_\_\_\_\_

**Address / City / State:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **Verifier's Email Address:** \_\_\_\_\_

Clearly **PRINT** name & title of employer representative verifying employment & completing this form.

\_\_\_\_\_  
*Signature of the supervisor/authorized personnel noted above*

\_\_\_\_\_  
**Date signed/verified**