LOUISIANA STATE BOARD OF NURSING

17373 Perkins Road, Baton Rouge, LA 70810 * (225) 755-7500 * Fax: (225) 755-7581 * www.lsbn.state.la.us *

VERIFICATION OF ADVANCED PRACTICE NURSING EDUCATION

PART I – APRN Applicant Information

Applicant Instructions: Fill out the **top** portion of this form and forward to the educational institution from which you obtained your advanced practice nursing education. This form must be completed and submitted to the Louisiana State Board of Nursing (LSBN) office **directly** by the educational institution. An **official** set of transcripts indicating an advanced practice nursing degree was **conferred** (or certificate issued if post-grad) must also be **mailed directly** to LSBN by the School.

Name (First, Middle, Maiden, Married):		
Street Address:		
City:	**State:**	**Zip Code:**
Last 4 Social Security #:		**Date of Birth:**
RN License Number:		**Expiration Date:**
Signature of Applicant:		**Date Signed:**

PART II – Verification of Advanced Practice Education

Educational Institution Instructions: Please complete the following information, noting any exceptions to the information requested. Please fill out all portions of this form and mail to the Louisiana State Board of Nursing (LSBN) at the address noted above. An **official set of the applicant's conferred transcripts** must also be mailed to LSBN ***directly*** from the School.

Name of Educational Institution: _____

I certify that _____ **completed the advanced nursing program**
print name of graduate above

indicated below and completed ALL requirements for conferring a Master's degree in nursing or Post Graduate award/ certificate as of the date this form has been signed and not after.

Type of Advanced Nursing Educational Program:		**Advanced Practice Role:**
☐ * **Certificate**	☐ **Post Masters/Grad Certificate**	☐ **Certified Nurse Midwife (CNM)**
☐ * **Diploma**	☐ **Doctorate**	☐ **Certified Registered Nurse Anesthetist (CRNA)**
☐ **Masters**		☐ **Clinical Nurse Specialist (CNS)**
☐ **Other** (specify): _____		☐ **Certified Nurse Practitioner (CNP)**

* *Certificate or Diploma only applicable if enrolled prior to December 1995*

Provide the *specific* APRN Role *and* Population Focus completed by graduate:_____
(Examples: CRNA; CNM; Family NP; Adult NP; Pediatric NP; Adult Psychiatric Mental Health CNS, etc.)

Date Enrolled: _____ **Date Completed (provide month, day, and year):** _____

(SEAL)

_____ _____
Signature of Program Administrator **Date Signed**

Revised: 9/99, 5/02, 1/04, 8/06, 10/07, 2/08, 1/09, 10/11, 3/12, 2/14, 10/24, 4/26