Department of Health – Health Professional Licensing Administration
District of Columbia Board of Nursing
899 North Capitol Street, NE; First Floor
Washington, DC 20002

NURSING LICENSURE VERIFICATION FORM

TO BE COMPLETED BY APPLICANT

Applicant's Name_____ SS# _____

Address _____

Telephone _____ E-mail _____

Name original license was issued under _____

License Number_____ State/Territory _____

TO BE COMPLETED BY LICENSING AUTHORITY

Please verify this registration and give the following information:

License Issued by: Examination □ Endorsement □ Date Issued: _____
Expiration Date: _____

Is applicant currently licensed? Yes □ No □

*Has licensee ever been disciplined? (Placed on Probation, License Denied, Revoked, Suspended, or Surrendered, etc.) Yes □ No □

Remarks _____

**If licensee is currently under disciplinary sanctions please forward all orders to the District of Columbia Board of Nursing along with this form.*

On behalf of the State/Territory of _____
I certify that the above statements are correct.

Verified by: _____

Board Seal Date: _____

Revised: 04/05