

# Nurse Form 2

## Certification of Professional Education

The University of the State of New York  
The State Education Department  
Office of the Professions  
Division of Professional Licensing Services  
www.op.nysed.gov

### Applicant Instructions

1. Use this form **ONLY** if your nursing school is located inside the United States or its territories; or, you earned a **BN, BSN or BScN degree from a University located in a Canadian province (except Quebec) after January 1, 2015.** (See Verifying Education Credentials from Non-U.S. Programs under Education Requirements.)
2. Complete Section I. In item 4, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 9.
3. Have the school you attended that made you eligible to take the NCLEX examination complete the appropriate parts of Section II. **If you graduated from a New York State licensure qualifying nursing education program after April 1, 1998, you do not need to submit this form.** Be sure to include any fee required by the school. The registrar must return the entire form in an official school envelope directly to the Office of the Professions at the address at the end of this form. This form will not be accepted if submitted by you.

### Section I - Applicant Information

1. Check what you are applying for  Registered Professional Nurse  Licensed Practical Nurse
2. Social Security Number \_\_\_\_\_ 3. Birth Date Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
(Leave this blank if you do not have a U.S. Social Security Number)
4. Print Your Name Exactly As It Appears On Your Application for Licensure (Form 1)  
Last \_\_\_\_\_  
First \_\_\_\_\_  
Middle \_\_\_\_\_
5. Mailing Address (You must notify the Department promptly of any address or name changes)  
Line 1 \_\_\_\_\_  
Line 2 \_\_\_\_\_  
Line 3 \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Country/  
Province \_\_\_\_\_
6. Name as it appears on your degree or diploma \_\_\_\_\_
7. Secondary institution attended \_\_\_\_\_
8. Nursing school attended \_\_\_\_\_  
Address \_\_\_\_\_  
Dates of attendance from \_\_\_\_\_ mo. \_\_\_\_\_ day \_\_\_\_\_ yr. to \_\_\_\_\_ mo. \_\_\_\_\_ day \_\_\_\_\_ yr.  
National council of State Boards for Nursing (NCSBN) Canadian Program Code (if applicable) \_\_\_\_\_
9. I request and give my permission to the school listed in item 8 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

**Section II - Certification of Professional Education**

**Instructions to Registrar:** Please complete and return both pages of this form in an official school envelope directly to the Office of the Professions at the address below. This form **will not be accepted if returned by the applicant**. This form should ONLY be completed by schools located **INSIDE OF THE UNITED STATES** or its territories; **or, if your school is located in a Canadian province (except Quebec) and conferred a BN, BSN or BScN degree to the applicant after January 1, 2015.**

- 1. Name of the applicant \_\_\_\_\_  
*(see Section I, item 6)*
  
- 2. Nursing School name \_\_\_\_\_  
  
Address \_\_\_\_\_  
*(Street)*  
\_\_\_\_\_  
*City* *(State/Province)* *(ZIP Code)* *(Country)*
  
- 3. Is this program located In the United States or its territories or a Canadian province other than Quebec?  Yes  No  
**If no, do not use this form.** If yes, complete the remainder of this form.
  
- 4. Dates on which the faculty approved the awarding of the degree or diploma **or** date degree awarded \_\_\_\_\_  
mo. day yr.
  
- 5. This program was approved as preparing for licensure as a Registered Professional Nurse or Licensed Practical Nurse by \_\_\_\_\_  
*(Name of state, U.S. territory or Canadian Province)*
  
- 6. NCLEX Program Code \_\_\_\_\_
  
- 7. Type of program  Baccalaureate  Diploma  Associate  Other \_\_\_\_\_
  
- 8. Title of degree awarded \_\_\_\_\_

**Certification - To be completed by the Registrar**

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.

\_\_\_\_\_  
Signature of Registrar

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Institution

\_\_\_\_\_  
Address

Institution Seal

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Email

**Return Directly to:** New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Unit, 89 Washington Avenue, Albany, NY 12234-1000, U.S.A..