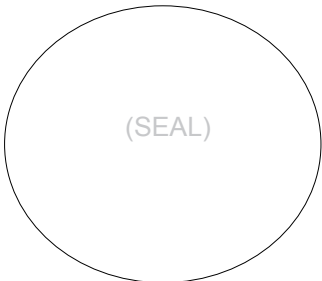




Washington State Department of
Health
 Nursing Care Quality Assurance Commission
 P.O. Box 47864
 Olympia, WA 98504-7864
 360-236-4703

Education Verification for Registered Nurses Educated Outside the United States

Applicant: Complete this section and mail to your school of nursing which you graduated.

Name	Last	First	Middle Initial
Date of Birth (mm/dd/yyyy)		Other names used	
Address			
City	State	Zip Code	County
High School Graduate <input type="checkbox"/> Yes <input type="checkbox"/> No			Social Security Number
If no, GED? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I hereby request this verification be completed and a transcript mailed to the Nursing Commission			
Signature of Applicant			Date
To be completed by the Chief Administrative Officer of the school of nursing from which the above named applicant graduated, certifying the following:			
Record name of graduate _____			
Name of Nursing School _____			
Location _____			
School approved by _____ School accredited by _____			
Date student entered program _____ Graduation/completion date _____			
Diploma/Degree earned by Student _____			
Please attach an official transcript (record of all subjects taken, including hour of class and weeks of clinical experience) for this applicant. This document must carry the school seal or stamp and signature of the chief administrator officer. Note: Please complete both sides			
		Signature _____	
		Title _____	
		Contact Email _____	
		Date _____	

Please respond to each item listed subject matter for Registered Nurse program:
 (some subjects matter may be integrated into fundamentals of other courses)

1. Subject Matter	Completed	Not Completed
a. Anatomy and Physiology (two terms with labs).....	<input type="checkbox"/>	<input type="checkbox"/>
b. Microbiology	<input type="checkbox"/>	<input type="checkbox"/>
c. Chemistry.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Pharmacology.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Nutrition	<input type="checkbox"/>	<input type="checkbox"/>
f. Communication.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Computations	<input type="checkbox"/>	<input type="checkbox"/>

2. Clinical Experience	Completed	Not Completed	Total number of clinical hours
a. Medical Nursing.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Surgical Nursing	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Obstetrics Nursing (pre and post partum care).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Post partum care of newborns.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Pediatric nursing (well and ill).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Psychiatric/mental health Nursing	<input type="checkbox"/>	<input type="checkbox"/>	_____

Return to the address listed on page 1 of this form.