

BUGINESS, CONSUMER SERVICES AND HOUSING AGENCY - GAVIN NEWSOM, GOVERNOR BOARD OF REGISTERED NURSING PO Box 944210, Sacramento, CA 94244-2100 P (916) 322-3350 | F (916) 574-8637 | www.rn.ca.gov



INTERNATIONAL LICENSE VERIFICATION

Send this form to the licensing regulatory agency where you were licensed.

PART I: To be completed by APPLICANT and for	varded to appropriate licer	sing agen	су.	
Name: (Last, First, Middle)			Previous Names: (Including Maiden)	
Current Street Address of Record:				
City:	Province or State:		Country:	Postal Code or Zip:
Name as it Appeared on Original License: (Last, Fi	irst, Middle)	Date of B	rth: (Month/Day/Year)
Country of Original Licensure:	Issue Date of Licens	e: Lico	License/Diploma Number:	
Name of School:	Graduation Date:	Тур	Type of Nursing Program: DIP BSN MSN Other	
Address of School:				
(City)	(Province or State)		(Country)	(Postal Code)
I hereby authorize all identified Licensing agencie	s to release my licensure of	lata to the	California Board o	f Registered Nursing.
Signature:				
Signature:			Date:	
PART II: To be completed by licensing agency and	d sent to the California Boa	rd of Nurs	ing listed at the to	o of this form.
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