Iowa Board of Nursing
400 SW 8th Street, Suite B
Des Moines, IA 50309-4685
515.281.3264
E-Mail: ibon@iowa.gov

VERIFICATION OF ORIGINAL LICENSE

Mail this form to your original state board of licensure
***IF** the state is **NOT** listed as participating through the NURSYS license verification database at*
www.nursys.com

A. TO BE COMPLETED BY APPLICANT

LAST NAME:	FIRST NAME:	MIDDLE NAME:	MAIDEN NAME:

ADDRESS Number and Street	City	State	Zip Code

NAME AND STATE OF NURSING PROGRAM COMPLETED

ORIGINAL LICENSE NUMBER		DATE OF ISSUANCE
	RN ☐ LPN ☐	

I hereby authorize the ________________________ Board of Nursing to provide the Iowa Board of Nursing the information listed below:

SIGNATURE OF APPLICANT:____ **DATE:** ________________

B. TO BE COMPLETED BY LICENSING AGENCY ONLY

LICENSE NUMBER	DATE OF ISSUANCE
TO PRACTICE AS A: Registered Nurse ☐ Licensed Practical Nurse ☐	**LICENSED BY:** Exam ☐ Endorsement ☐
CURRENT LICENSE STATUS: Active ☐ Inactive ☐	**DATE LICENSE EXPIRES**

Has this license ever been encumbered in any way, e.g. revoked, suspended, surrendered, restricted, limited, placed on probation?
Yes ☐ No ☐ Is there any action pending? Yes ☐ No ☐

If yes to either of the above questions, please include copies of public documents.

NAME OF ACCREDITED NURSING EDUCATION PROGRAM

CITY AND STATE	YEAR OF GRADUATION	APPROVED PROGRAM Yes ☐ No ☐

RECORDS INDICATE GRADUATION FROM:	High School ☐	High School Equivalency ☐

I certify that the information listed above is correct.

SIGNATURE:____ **TITLE:** ______________________________

STATE: ____ **DATE:** ______________________________

SEAL
Required