



K. NURSING SCHOOL PROGRAM CODE

NCSBN Number \_\_\_\_\_

**SUBMISSION OF THIS FORM PRIOR TO PROGRAM COMPLETION WILL RESULT IN ITS RETURN TO THE PROGRAM FOR CORRECTION.**

I certify that the educational information recorded herein is true and correct according to the official records of this institution.

\_\_\_\_\_  
Print Name of Dean or Director of Nursing

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Signature of Dean or Director of Nursing

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

SCHOOL SEAL OR NOTARY SEAL

**NOTE:** If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Date of Expiration

\_\_\_\_\_  
Signature of Notary Public

**RETURN THIS FORM TO APPLICANT**

NAME (Last, First, MI):

SS#:

Profession: