

Arkansas State Board of Nursing

University Tower Building
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Little Rock, Arkansas 72204

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VERIFICATION OF NATIONAL CERTIFICATION

Part I: To be completed by the applicant and forwarded to the certifying body.

Name (Last, First, Maiden/Middle):		
Street Address:		
City:	State:	Zip Code:
Social Security Number:	Date of Birth:	
Certification Number:	Expiration Date:	
Signature:	Date:	



Part II: To be completed by the certifying body and forwarded directly to the Arkansas State Board of Nursing at the address shown above.

This is to certify that the person identified above has met the requirements for certification or decertification by the:		
Name of Certifying Agency		
Specialty Area of Certification		
Date of Certification	Certification Number	Expiration Date
Authorized Signature of Certifying Agency		Date
Print or Type Name and Title		Seal