

Advanced Practice Registered Nurse (APRN) License Application

Personal Information

Full Name:

Date of Birth:

Social Security Number:

Home Address:

Phone Number:

Email Address:

Education

Nursing School Name:

Degree Awarded:

Date of Graduation:

Licensure

Registered Nurse License Number:

State of Issuance:

Expiration Date:

Specialty Certification

APRN Specialty (e.g., FNP, CRNA, CNS, CNM):

Certifying Body:

Certificate Number:

Date Certified:

Work History

Current/Most Recent Employer:

Position Title:

Dates Employed:

Attestation

I attest that the above information is true and complete to the best of my knowledge.

Submit Application