

NORTH CAROLINA BOARD OF NURSING

NURSE PRACTITIONER

Licensure Biography from Other States

Complete the top portion of this form and forward one copy to each licensing board in states where you have held or do hold a nurse practitioner license/approval. State Boards vary; it is recommended you contact each board(s) prior to mailing this form to find out any requirements/fee for providing this verification.

Make as many copies of this form as needed.

I am applying for registration as a Nurse Practitioner in North Carolina.

I was granted approval/license # _____ on _____ by the State of _____.

The NC Board of Nursing requires information regarding my license/approval. This is my request for you to respond to the questions below and authorizes you to release any information to the NC Board of Nursing.

Printed or Typed Name

Signature (**ORIGINAL**)

Social Security Number

Address

Date of Birth

NURSYS: IMPORTANT INFORMATION RELATED TO NURSE PRACTITIONERS:

Although NURSYS provides information related to the Registered Nurse license, it **DOES NOT** provide information related to Nurse Practitioner approval/license in most states. Therefore, this form, or an official verification, must be completed and returned to the North Carolina Board of Nursing in order to process the licensure biography portion of the NP application.

STATE LICENSING AGENCY COMPLETING FORM:

Please complete and return this form to: **NC Board of Nursing, Attn: Teresa Werlau, P. O. Box 2129, Raleigh NC 27602.**

This is to certify that the records of the _____ Board of Nursing or Medical Board indicate that _____ NP was issued license/approval number _____ on _____, (date) as a nurse practitioner.

Respond to the following questions:

- | | | | |
|----|---|--|-----------------------|
| 1. | Is this license/approval current?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | Expiration Date _____ |
| 2. | Is this license/approval in good standing?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3. | Have any charges ever been filed against this nurse practitioner?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 4. | Do you know of any information that may discredit this person?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 5. | Do your files indicate any derogatory information?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 6. | Have you received any complaints against this nurse practitioner?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 7. | Has this nurse practitioner been investigated by your Board?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 8. | Have you received any information about this nurse practitioner from the National Practitioner Data Bank or HIPDB?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

For "YES" answers to questions #3-8, please attach an explanation.

Authorized Original Signature of Individual Completing Form

Date