

# VERIFICATION OF EMPLOYMENT (OUTSIDE OF KENTUCKY)

ATTACHMENT 1

**Complete this form ONLY if you are reinstating your RN/LPN Kentucky license.**

### *To the Applicant*

Complete this section of the Verification of Employment form. In the spaces below, list an employer who will verify that you practiced as a nurse 500 hours during the past five years. **THE EMPLOYER MUST MAIL OR FAX THIS FORM TO THE KENTUCKY BOARD OF NURSING.**

\_\_\_\_\_

**Applicant's Last Name** (print clearly)

\_\_\_\_\_

**Applicant's First Name** (print clearly)

\_\_\_\_\_

**Social Security #** (print clearly)                      **Year of Graduation from Basic PON**                      **Employed As:**    RN     LPN

\_\_\_\_\_

**Employing Facility** (print clearly)

\_\_\_\_\_

**Facility's Address** (print clearly)

\_\_\_\_\_

**City** (print clearly)    **State**                      **Zip Code** (print clearly)

\_\_\_\_\_

**Facility's Phone Number** (print clearly)                      **Employed From (Month/Year)**                      **Employed To (Month/Year)**

### *To the Employer/Previous Employer*

Complete this section of the Verification of Employment form and **MAIL OR FAX THIS FORM DIRECTLY TO THE KENTUCKY BOARD OF NURSING.**

Has the individual named above been engaged in active nursing practice for at least 500 hours during the past five years at this facility?

**Yes**     **No**                      **If "No," list the number of hours of practice:** \_\_\_\_\_

Did this individual hold a current nursing license at the time of employment?    **Yes**     **No**                      License was issued by state of: \_\_\_\_\_

\_\_\_\_\_

**Facility Name** (print clearly)

\_\_\_\_\_

**Employer's Name** (print clearly)

\_\_\_\_\_

**Employer's Title** (print clearly)

\_\_\_\_\_

**Employer's Phone Number** (print clearly)                      **Signature**                      **Date**

<b>For Office Use Only</b>		
Person Contacted at Above Facility: _____	Employment Verified?	If no, explanation received:
Title of Person Contacted: _____	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	_____
Date & Time Contacted: _____		_____
		_____