PLEASE PRINT OR TYPE

Kentucky Board of Nursing
312 Whittington Pky, Suite 300
Louisville, KY 40222-5172

ARNP ATTACHMENT 2

VERIFICATION OF ELIGIBILITY FOR NATIONAL CERTIFICATION

Complete this form ONLY if you do not hold current national certification.

Candidate

Complete this section only and forward to the national certification organization to which you have applied. Contact the national certification organization regarding any fees that may be required for this service.

The national certification organization must mail this form to the attention of the "ARNP Licensure Specialist" at the Kentucky Board of Nursing. The address is provided at the top of the form.

Candidate's Last Name:

Candidate's First Name:

Advanced Practice Designation: ◯ **Anesthetist** ◯ **Practitioner** ◯ **Midwife** ◯ **Clinical Specialist**

National Certification Organization:

Please release my test results to the Kentucky Board of Nursing.

Signature

Date: ☐☐ - ☐☐ - ☐☐☐☐

To be Completed by the National Certification Organization

Complete this portion of the Verification of Eligibility for National Certification form and return to the attention of the "ARNP Licensure Specialist" at the Kentucky Board of Nursing. The address is provided at the top of this form. For additional information, contact the ARNP Licensure Specialist at 502-429-3329.

Examination Information

◯ **First-Time Candidate** **or** ◯ **Repeat Candidate**

◯ **Scheduled to Take Exam** **or** ◯ **Eligible to Take Exam**

Beginning ☐☐ - ☐☐ - ☐☐☐☐

Through ☐☐ - ☐☐ - ☐☐☐☐

Verification Statement

This is to verify that the candidate listed above has met eligibility requirements and has applied to take the examination for certification for advanced practice nursing.

SEAL

Name: _____

Title: _____

Organization's Phone #: _____ **Ext:** _____

Date: _____