

VERIFICATION OF EMPLOYMENT  
(For employment outside of the state of Kentucky)

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.

Applicant's Last Name (print clearly)

Applicant's First Name (print clearly)

Applicant's Maiden Name (if applicable)

Social Security Number

Date of Birth

Employed as:  APRN  RN  LPN

Employing Facility

Facility's Address

City

State

Zip Code

Facility Phone Number

Employed From (Month/Year)

Employed To (Month/Year)

TO 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 State license issued from: \_\_\_\_\_

Facility Name

Employer's Name

Employer's Title

Employer's Phone Number

Employer's Signature

Date

For Office Use Only

Employment Verified?  Yes  No

If no, explanation received:

Person Contacted at Above Facility: \_\_\_\_\_ Title of Person Contacted: \_\_\_\_\_

Date & Time Contacted: \_\_\_\_\_