



New Jersey Office of the Attorney General

Division of Consumer Affairs
New Jersey Board of Nursing
124 Halsey Street, 6th Floor, P.O. Box 45010
Newark, New Jersey 07101
(973) 504-6430

Pharmacology Continuing Education Compliance Report Form

Name: _____ R.N. License Number: _____

A.P.N. Specialty/Category: _____

I certify that the foregoing statements made by me are true to the best of my knowledge. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment, including but not limited to suspension or revocation of a license and/or certification under N.J.S.A. 45:1-21.

Signature: _____

Title of Program Attach copies of the certificates*	Date	Program Provider	Contact Hours
1 contact hour = 50 minutes 1 C.M.E./1 A.M.A. = 60 minutes = 1.2 contact hours A total of 30 contact hours is required.			Total _____

*Attach a copy of the program certificate of completion/attendance (usually one page) for each listing noted above to add up to 30 contact hours.



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**Advanced Practice Nurse Certification Verification Request:
Certification of Advanced Nursing Practice**

Directions: Complete only the top portion of this license verification form and forward it to the Board of Nursing in the state(s) in which you are or have been licensed. The board(s) should complete the form and return it to the New Jersey Board of Nursing. Note: Be advised that the board(s) completing the form may charge a fee for license verification. Please call the board(s) to check on fees for license verification prior to submitting this form.

Applicant name: _____
First name Middle name Last name Maiden name, if applicable

Current address: _____
Street City State ZIP code

This section is to be completed by the State Board of Nursing.

I hereby certify that _____ was issued certification/licensure
Name

as a _____
Clinical Specialty

(Check one): Nurse Practitioner Clinical Nurse Specialist

in the State of _____ on _____
Date

This certification/licensure expires on _____
Date

Has any disciplinary action been taken against any license or certification issued to this nurse to practice nursing?

(Check one): Yes No

If "Yes," please explain:

I certify that the statements contained herein are true to the best of my belief, and I recommend this nurse for advanced nursing practice certification in the State of New Jersey.

Executive Officer

New Jersey Board of Nursing

Date

*Official
Seal*

Return to: New Jersey Board of Nursing, P.O. Box 45010, Newark, N.J. 07101