KANSAS STATE BOARD OF NURSING

LANDON STATE OFFICE BUILDING

900 SW JACKSON, SUITE 1051

TOPEKA, KS 66612-1230

IV Therapy Annual Report

Name of Provider: _____

Provider Number: _____

IV Provider Number: _____

Address of Provider: _____

Telephone Number: _____

Email Address: _____

IV Course Coordinator: _____

Reporting Year: _____

Did you provide IV Therapy Courses this reporting year? ◯ Yes ◯ No

If you answered Yes, please fill in the information below.

Date of Course	RN's Enrolled	LPN's Enrolled	LPN's Withdrew	LPN's Failed	LPN's Certified

Attestation

I realize that this application is a legal document and that by signing below I am declaring under penalty of perjury under the laws of the State of Kansas that the information I have provided is true and correct to the best of my knowledge.

If all the above information is correct please sign below .

Otherwise please go back and correct any information that is necessary.

Signature: _____ *Date:* _____

Submissions should be emailed to KSBN_Education@ks.gov