Kansas State Board of Nursing
Landon State Office Building
900 SW Jackson, Ste. 1051
Topeka, KS 66612-1230
K.A.R. 60-2-103

Faculty Qualification Report (FQR)

To be submitted to KSBN by Nurse Administrator within 30 days of appointment

☐ Initial FQR ☐ Update

Name of Appointee: (name as it appears on their nursing license)

Last Name _____ First Name _____ Middle Name: _____
Nursing License # : _____ License Expiration Date: _____ State (if other than KS): _____
Multi-State license? ☐ Yes ☐ No SSN: _____

Employment Information: **Appointment Date**: ____/____/_____

Name of Program: _____
Address of Program: _____

Type of Program: ☐ APRN ☐ BSN ☐ ADN ☐ PN

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Adjunct ☐ Other

Appointment Teaching and Clinical Responsibilities:

Title of Course(s) – if not obvious, include Clinical Specialty	Credit Hours	Lecture	Clinical Instruction

Appointee Education Information:

Initial Prelicensure Preparation in Nursing:** ☐ ADN ☐ Diploma ☐ BSN ☐ Other

Graduation Date (mm/yy): _____ /_____

Name of Nursing Program: _____

City / State of Program: _____

Additional Education Obtained**:

College / University	Major	Degree Awarded		Presently Enrolled	Credits Earned
		☐ Yes /Yr_____	☐ No		
		☐ Yes /Yr_____	☐ No		
		☐ Yes /Yr_____	☐ No		

**Include transcripts for original RN licensure degree and any further education ☐ Degree plan included if applicable

_____ _____

Signature of Appointee Date Signature of Program Administrator Date

Date: _____ **Nursing Education Compliance Officer: _____**

Official Use Only: Transcripts: ☐ ADN ☐ DIP ☐ BS ☐ BSN ☐ MS ☐ MSN ☐ DNP ☐ EdD ☐ PhD

☐ Hire Exception: _____ to _____

☐ Degree Plan: Proposed Grad Date _____

Rev 10/2019