



Carol Moreland, MSN, RN
 Executive Administrator

Kansas State Board of Nursing

Sam Brownback, Governor

Verification of Advanced Practice Licensure Request Form

This form is to request that your Kansas AP license information be sent to another state for licensure.

To be completed by the applicant and forwarded to the State of Kansas Board of Nursing along with a check or money order for \$30 per license, per state for each verification to be sent.

*Name (Last, First Middle, Maiden)		*Previous Name(s)		
Current Address		City	State	Zip
*Date of Birth	*Social Security Number	*Nursing License(s) (check license(s) to verify) <input type="checkbox"/> APRN/NP <input type="checkbox"/> CNS <input type="checkbox"/> RNA		
Name as appeared on original license (Last, First, Middle, Maiden)		City of Nursing Program	State	Date of Completion
Original State of Licensure	Issue Date of Original Licensure	Original License Number(s)		
*State(s) in which verification(s) is to be sent:				

*Required Information

Please check this box if the above noted address is new and you would like us to update our database.

I hereby authorize the Kansas State Board of Nursing to release my AP licensure data to the above noted state(s) Board of Nursing.

 *Licensee Signature

 Date