Washington State Department of Health
Nursing Care Quality Assurance Commission
P.O. Box 47864
Olympia, WA 98504-7864
360-236-4703

Education Verification for Nurses Educated Outside of Washington State

Applicant: Complete this section and mail to your school of nursing which you graduated.

Name Last	First	Middle Initial
Date of Birth (mm/dd/yyyy)	Other names used	
Address		
City	State	Zip Code	County
High School Graduate ☐ Yes ☐ No If no, GED? ☐ Yes ☐ No	Social Security Number	

I hereby request this verification be completed and a transcript mailed to the Nursing Commission

Signature of Applicant Date

*This section below **must be completed by the dean** of the nursing education program or the designated nursing faculty member from the program the applicant graduated, certifying the following:*

Record name of graduate _____

Name of Nursing School _____

Location _____

School approved by _____ School accredited by _____
(Regional accrediting body and national nursing accrediting body)

Date student entered program _____ Graduation/Completion date _____

Diploma/Degree earned by Student _____

Please attach an official transcript (record of all subjects taken, including hour of class and weeks of clinical experience) for this applicant. This document must carry the school seal or stamp and official signature.

(SEAL)

Signature _____
(Dean or Nursing Facility Member)

Printed Name _____
(Dean or Nursing Facility Member)

Title _____

Contact Email and Phone Number _____

Date _____

Student Name_____

Please respond to each item listed subject matter for Nurse program:
(some subjects matter may be integrated into fundamentals of other courses)

Subject Matter	Completed	Not Completed
Anatomy and Physiology (two terms with labs)		
Microbiology		
Chemistry		
Pharmacology		
Nutrition		
Communication		
Computations/Dosage Calculations		

Clinical Experience	Completed	Not Completed	Course Number	Total Number of Clinical Hours	Total Number of Simulation Hours
Medical Nursing					
Surgical Nursing (care of pre- and post-op surgical patients)					
Obstetrics Nursing (pre- and post-partum care)					
Postpartum Care of Newborns					
Pediatric Nursing (well and ill)					
Psychiatric/Mental Health Nursing					
Preceptorship					
Other Clinical Hours					
TOTAL CLINICAL HOURS IN THE NURSING PROGRAM					

Please list the facility(s) and dates where clinicals were completed to include the name and location.

Return to the following mailing address:

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