Nursing Transition Program
Verification of Practice

By my signature, I affirm that ____________________________________________
(Print full name of LPN)

☐ is working or ☐ has worked in the role of Licensed Practical Nurse.
(check one)

Employment Dates:
Start: _________________ End: _______________ ☐ still employed

Facility (check one):
☐ Medical/Surgical acute care hospital or ☐ Skilled Nursing Facility.
Or ☐ Other

Name and type of facility: ____________________________________________

Total hours worked for the last year: ________________

Employer Signature from Nursing or Human Resource Department

Date

Printed Name and Title

Printed Name of Agency/Facility

Contact Phone Number

Applicants may duplicate this blank form if multiple copies are needed. Revised 9/2022.