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.