



INSTRUCTIONS FOR VERIFICATION OF EMPLOYMENT FORM

GENERAL INFORMATION

In accordance with the *Arkansas State Board of Nursing Rules*, a nurse who is reinstating a nursing license to active status after greater than five (5) years or an applicant for licensure by endorsement who has not been engaged in the active practice of nursing for a period greater than five (5) years shall document completion of the following:

- a. Active practice of nursing for a minimum of one thousand hours (1,000) within the two years immediately prior to application. Verification of employment shall be submitted (Option a is not applicable for endorsement applicants); or
- b. Completion of an Arkansas board approved refresher course within one (1) year of the date of application; or
- c. Graduation from an approved nursing education program within one year of the date of application; and
- d. Provide other evidence as requested by the Board.

Active Practice is defined as the act of performing for compensation those acts within specified scope of practice and authorized by the board.

In order to document active nursing experience, state law requires verification of employment. Additional requirements for endorsement or reinstatement may be reviewed by accessing our website at www.arsbn.org.

Instructions to the applicant:

1. Complete the top section of the Verification of Employment form.
2. Forward the form and instructions to your employer/former employer at the facility where you were employed for the year prior to application.
3. You may reproduce as many copies of this form as needed for additional employers.
4. The Verification of Employment form must be completed by the RN Director, Supervisor, or Human Resource officer, and **returned to you**.
5. If you already have an application on file with the Board and are submitting additional active nursing experience, the Verification of Employment form may be submitted to the Board by uploading the form to your nurse portal account. *Be advised that Verification of Employment forms that appear to have been altered will not be accepted. The form WILL BE verified with identified employer for validity. Discrepancies or false statements included in the application or form can result in licensure denial.*
6. Upload completed form(s) to the Arkansas State Board of Nursing.
7. You may access licensure status online at www.arsbn.org

Instructions to employer:

The applicant identified on the Verification of Employment form is applying for licensure as a nurse in Arkansas. In order for the applicant to provide evidence of active nursing experience versus taking a refresher course, State law requires the Board to obtain verification of employment, including the number of hours worked within the two years prior to application.

1. Please complete the bottom part of the Verification of Employment form.
2. Affirm that the applicant worked in the active practice of nursing in your facility.
3. Return the Verification of Employment form to the applicant in a sealed business envelope. It is the applicant's responsibility to collect the form(s) and submit with the application for licensure.



VERIFICATION OF EMPLOYMENT FORM

DIRECTIONS: The applicant shall complete the top section of this form, and then forward it to your employer/former employer. Reproduce as many copies of this form as needed for additional employers. Return completed form(s) to the Arkansas State Board of Nursing per delineated instructions. In lieu of completion of a refresher course, a nurse must provide verification of employment of a minimum of 1000 hours of active practice in nursing within the two years immediately prior to application. (Verification of employment hours not applicable for endorsement applicants.)

FALSIFICATION OF THIS FORM IS GROUNDS FOR DISCIPLINARY ACTION AGAINST YOUR LICENSE

Applicant Name _____
First Middle Last Other

*Name while employed at this facility _____

Nursing License Number _____ Social Security Number _____

Applicant Address _____
Street City State Zip Code

Applicant Phone Number _____ Email address _____

Name of facility where active nursing experience was obtained _____

I hereby request and authority my employer/former employer to release the information requested on this form to the Arkansas State Board of Nursing for licensure purposes.

Printed name of applicant Signature of applicant Date

This section is to be completed by employer and cannot be signed by the applicant.

The above-named individual was employed as a nurse at this facility during the two years immediately prior to this application date: (check one) Yes No

The above-named nurse actively practiced nursing for a minimum of 1,000 hours during the two years immediately prior to this application date: (check one) Yes No If no, explain _____

Title, credentials and position held by individual during time of employment _____

Name of employer _____

Address of employer _____
Street City State Zip Code

Telephone number of employer _____ Email _____

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for the purpose of licensure is true and correct.

Printed name of agency representative Date

Signature of agency representative/title who can verify/confirm number of hours employed