NURSE LICENSURE/NURSING DIPLOMA VERIFICATION

Verification of your nursing licensure in the country where you completed your nursing education is required. Complete Section 1 of this form and then send it to the authority that licenses nurses in the country where you completed your nursing education. The licensure authority must complete Section 2 and then send the completed form directly to SpanTran by email or by postal mail or courier. SpanTran will not accept completed forms sent by you to SpanTran.

IF THE COUNTRY WHERE YOU COMPLETED YOUR NURSING EDUCATION DOES NOT LICENSE NURSES OR IF YOUR NURSING DIPLOMA ALLOWS YOU TO PRACTICE AS A NURSE IN THAT COUNTRY, complete Section 1 of this form and then send it to the school where you completed your nursing education. Your school must complete Section 2 and then send the completed form directly to SpanTran by email or by postal mail or courier. SpanTran will not accept completed forms sent by you to SpanTran.

IF THE COUNTRY WHERE YOU COMPLETED YOUR NURSING EDUCATION REQUIRES NURSES TO BE LICENSED BY A GOVERNMENTAL ORGANIZATION, THIS FORM MUST BE COMPLETED BY THAT ORGANIZATION. WE WILL NOT ACCEPT FORMS COMPLETED BY YOUR NURSING SCHOOL.

SECTION 1: APPLICANT COMPLETE THIS SECTION

City

Street

Family name(s)	First name	Other names
2. YOUR NAME AS IT APPEARS ON Y	YOUR NURSE LICENSE OR DIPLOMA	
Family name(s)	First name	Other names
3. DATE OF BIRTH	4. SPANTRAN NUMBER (if known)	
month / day	/ year	
5. APPLICANT SIGNATURE		
	JRE AUTHORITY OR NURSING SCHO	OL COMPLETE THIS
	JRE AUTHORITY OR NURSING SCHO	OL COMPLETE THIS
SECTION		OL COMPLETE THIS
SECTION 2: NURSE LICENSUSECTION 1. NAME OF NURSE LICENSURE AUT		OL COMPLETE THIS
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SECTION 1. NAME OF NURSE LICENSURE AUT	THORITY OR NURSING SCHOOL	OL COMPLETE THIS

Province/State

Postal Code

Country

3. UNDER WHICH AUTH	HORITY CAN NURSES IN YOUR COUNTRY I	PRACTICE THEIR PROFESSION?
☐ National Examination	☐ Registration with this licensure authority	☐ Diploma from a recognized/accredited nursing program
☐ Other (please explain)		
4. WHEN WAS THE APP	PLICANT LISTED IN SECTION 1 ABOVE FIRS	T LICENSED AS A NURSE IN YOUR COUNTRY?
month / day / yea	r	
5. APPLICANT'S CURRE	NT NURSE LICENSURE STATUS	
☐ Active/current ☐ Expir	ed □ Inactive	
6. HAS THE APPLICANT REVOKED OR SUSPEN		RK AS A NURSE IN YOUR COUNTRY EVER BEEN
☐ No ☐ Yes (list the nurs	se licensure revocation or suspension dates)	
7. SIGNATURE OF PERS	ON WHO COMPLETED THIS FORM	
		month / day / year
8. NAME OF PERSON W	VHO COMPLETED THIS FORM	
Name		email address

RETURN THIS FORM BY EMAIL TO <u>VERIFICATION@SPANTRAN.COM</u> USING AN OFFICIAL INSTITUTIONAL EMAIL ACCOUNT. EMAILS SENT USING AN OPEN SERVER EMAIL ADDRESS, SUCH AS YAHOO MAIL OR GMAIL, WILL NOT BE ACCEPTED.

Completed forms can also be sent directly to SpanTran in a sealed envelope with your institutional stamp or seal on both this form and the envelope. Send the sealed envelope to:

SpanTran: The Evaluation Company 2400 Augusta Drive, Suite 451 Houston, TX 77057 USA