Secretary of State
Office of Professional Regulation

NURSING

Verification of Nursing Assistant Program
Programs Outside of Vermont

Form must be sent to the Office directly from the Program: SOS.OPRLicensing1@vermont.gov

Information to be completed by the Applicant

Name of Student/Applicant:_____ **Date of Birth:**____/____/____
MM DD YYYY

I hereby authorize the nursing assistant program to furnish the information requested on this form and submit it with my application to the Vermont Board of Nursing.

Signature:_____ **Date:**____/____/____
MM DD YYYY

Information to be completed by the Nursing Assistant Program – *Please Print Clearly*

Name of Nursing Assistant Program:_____

Name of Program Administrator/Primary Instructor:_____

Position/Title:_____

Telephone Number: _____

Email Address: _____

Mailing address:_____
Street or PO Box

I hereby verify that_____**was admitted into the nursing assistant program**
Name of Student/Applicant

on____/____/____**and completed the program requirements on**____/____/____
MM DD YYYY MM DD YYYY

This nursing assistant education program offers a course consisting of:

_____ **+** _____ **=** _____
# of Classroom & Lab Hours ***# of Clinical Hours*** ***Total # of Program Hours***

Signature of Program Administrator/Primary Instructor:_____

Date:____/____/____
MM DD YYYY

(Official School Seal/Stamp)