GEORGIA BOARD OF NURSING
237 Coliseum Drive
Macon, Georgia 31217

VERIFICATION OF EMPLOYMENT FOR APPLICANTS FOR INITIAL AUTHORIZATION

Section I (To be completed by applicant)

Submit this form to your employer to verify your employment and the numbers of hours worked. The name and address of your employer on this form must match the name and address you listed under "Employment History" on your application. Ask the employer to complete this form and place it in a sealed envelope for you to submit with your application or submit it by email to nursing@sos.ga.gov or by fax to 877-371-5712.

Applicant Last Name:	Applicant First Name:	
Physical Address:		
City:	State:	Zip:
Phone:	Email:	

I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia Board of Nursing. I understand this information is required as part of the application for licensure process.

____________________________ Applicant Signature

____________________________ Date

Section II (To be completed by employer)

Please complete the form in its entirety. A separate form must be completed for each position held. Be sure to accurately document the employee's position/title and whether or not licensure as a registered nurse was required. The completed and notarized form may be provided to the applicant or submitted directly to the Georgia Board of Nursing by email to nursing@sos.ga.gov or by fax to 877-371-5712.

Facility/Business/Employer Name:		
Physical Address:		
City:	State:	Zip:
Phone:	Email:	

Employer Information – Please Answer Each Question:

Is this a federal agency of the United States Government? ❐ No Yes ❐

Is this an acute care inpatient hospital? ❐ No Yes ❐

Is this a long term acute care facility (LTAC)? ❐ No Yes ❐

Is this an ambulatory surgical center or obstetrical facility as defined in O.C.G.A. §31-6-2? ❐ No Yes ❐

Is this a skilled nursing facility which has at least one hundred (100) beds and provides health care to patients with similar health care needs as those patients in a long term acute care facility? ❐ No Yes ❐

Applicant's Position/Title:

Is an APRN license a qualification/requirement for employment in this position? ❐ No Yes ❐

If different location than the employer listed on the first page, please identify the physical location where the employee practiced		
Facility/Business/Employer Name:		
Physical Address:		
City:	State:	Zip:
Phone:	Email:	

Dates of Employment:

Employed From_________________________(Month/Year) to _________________________(Month/Year)

Were there any periods of extended absence during employment? ❐ No Yes ❐

If yes, please provide dates"_________________________(Month/Year) to _________________________(Month/Year)

Please complete the grid below:

Year	**Hours Worked Per Year**	**Job Title/Description**

I hereby certify that I am the custodian of records at the facility listed on this form and the information submitted on this form are true and correct statements of this applicant's employment with our facility.

_______________________________________ Employer Representative Printed Name

_______________________________________ Employer Representative Title

_______________________________________ Employer Representative Signature

Sworn to and subscribed before me this ______ day of _____________, 20______.

_______________________________________ Signature of Notary Public

_______________________________________ Commission Expiration Date

- THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY -