The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Nurse Practitioner Form 2B
Verification of Instruction in New York State and Federal Laws Related to Prescriptions and Record Keeping

Use this form ONLY if you have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.

Use this form ONLY if you have completed a program located outside of New York State.

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appear on your Application for Certification (Form 1). Be sure to sign and date item 9.
2. Send the entire form to the school/institution/professional association where you completed instruction in New York State and federal laws relating to prescriptions and record keeping. Ask them to complete Section II and forward **both pages** of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required. **This form will not be accepted if submitted by the applicant or any party other than the school official.**

Section I: Applicant Information

1. Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)

2. Birth Date Month Day Year

3. Print Name
Last
First
Middle

5. Telephone/Email Address
Daytime Phone
☐ Home or ☐ Business
Area Code Phone

Email Address (please print clearly)
☐ Home or ☐ Business

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address ☐ Home or ☐ Business
(You must notify the Department within 30 days of any address or name changes)
Line 1
Line 2
Line 3
City
State ZIP Code
Country/ Province

6. New York State DMV ID Number (Driver or Non-Driver ID)
(Leave this blank if you do not have a New York State DMV ID Number)

7. Print name under which course was completed (if different from above)

8. Name of school/institution/professional association where course was completed

Address

9. I request and give my permission to the school/institution/professional association listed in item above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate

Signature Date

Section II: Certification of Professional Education

Instructions to School/Institution/Professional Association: Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of the form. **This form will not be accepted if returned by the applicant or any other party.**

1. It is hereby verified that _____
(see Section I, item 7)

completed instruction in New York State and Federal laws related to prescriptions and record keeping.

2. This course was ☐ part of a nurse practitioner program, or

☐ supplementary course.

3. Date(s) of the course ____ ____ ____ (mo. day yr.) and ____ ____ ____ (mo. day yr.)

4. The length of the course was _____ (semester hours) or _____ (clock hours)

Attestation

I hereby attest that to the best of my knowledge and belief the information in Section II is an accurate record of the completion of a course in prescription and record keeping laws of the individual named on this form.

Signature _____ Date _____

Print Name _____

Title or official position _____

Institution _____

Address _____

_____

Institution Seal

Telephone _____ Fax _____

Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000. **OR, Submit this form to the Department by E-mail at DPLSEduc@nysed.gov.**