



**SECTION II: CERTIFICATION OF NURSING EDUCATION**

**INSTRUCTIONS:** Please complete and return both pages of this form with an official transcript in an official armed forces envelope directly to the Office of the Professions at the address below. Do not return this form to the applicant. This form will not be accepted if returned by the applicant.

(1) Name of applicant \_\_\_\_\_  
*(see Section I, item 5)*

(2) U.S. armed forces program name: \_\_\_\_\_  
  
Address: \_\_\_\_\_  
*(Street) (City) (State) (Zip Code) (Country)*

(3) Description of U.S. armed forces program

1. Was the program at least nine continuous months in length?  Yes  No

If NO, give length of program \_\_\_\_\_.

2. Did the program include classroom instruction and supervised clinical experience?  Yes  No

3. Dates of applicant's attendance were from \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.  
*mo. day yr. mo. day yr.*

**CERTIFICATION**

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the nursing program of the individual named on this form.

Signature of Official \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*mo. day yr.*

Print name \_\_\_\_\_

Title of position \_\_\_\_\_

U.S. armed forces branch \_\_\_\_\_

Address \_\_\_\_\_

**INSTITUTION SEAL**

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

**Return Directly to:** New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Unit, 89 Washington Avenue, Albany, NY 12234-1000.