

Section II: Certification of Nursing Education

Instructions to the Registrar: Complete Section II to document the applicant's education. Sign and date the Certification. Return the entire form along **with an official transcript** documenting completion of the program in an official school envelope **directly** to the Office of the Professions at the address at the end of this form. **Form 2F will not be accepted if submitted by the applicant.**

Name of the applicant _____
(see Section I, item 7)

1. Nursing school name _____
Former school name _____
Address _____
(Street)
_____ *City* _____ *(State/Province)* _____ *(ZIP Code)* _____ *(Country)*

2. Nursing Program Information

Length of the program _____ Language of instruction used _____

Date of admission _____ Date of completion _____
mo. day yr. mo. day yr.

Years of education required for admission _____ Date of graduation _____
mo. day yr.

Title of degree or diploma awarded _____ Date degree or diploma was awarded _____
mo. day yr.

Type of program Baccalaureate Diploma Associate Other _____

This program was approved as preparing for licensed practice as a general or professional nurse or as an auxiliary/second level nurse by:

Name of the Registration Authority who approved this program _____

Initial date the program was approved by the Registration Authority _____
mo. day yr.

If NOT approved for general nursing practice, please explain _____

Note: An official transcript or marksheets is issued by the school showing completed courses by year and grades and bears original school official's signature(s) and an original school seal(s). It must be received directly from the school along with this form in a sealed official school envelope.

Certification - To be completed by the Registrar:

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 professional education of the individual named on this form.

Signature of Registrar _____ Date _____
Print Name _____
Title or official position _____
Institution _____ Institution Seal
Address _____
Telephone _____ Fax _____ Email _____

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.