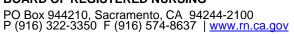


## **BOARD OF REGISTERED NURSING**





## REQUEST FOR TRANSCRIPT PUBLIC HEALTH NURSE CERTIFICATION

Send this form to your baccalaureate, entry-level masters or master's school of nursing. If you need to contact more than one school, this form may be reproduced. Transcripts must include all completed course work and reflect the degree awarded and date conferred. An official transcript must come directly from the school of nursing to the Board of Registered Nursing. Transcripts are not accepted from applicants.										
NAME:	JAME: Last First				Middle			Previous Names (Including Maiden):		
ADDRES					City		State			
	S. SOCIAL SECURITY NUMBER or DIVIDUAL TAXPAYER			BIRTHDATE:				TELEPHONE NUMBER: Home: ( )		
		ON NUMBER:					Work: ( )			
				Month	Day	Year				
NAME OF BSN/ELM/MSN NURSING SCHOOL:								YEARS ATTENDED:		
								to		
LOCATIO	ON:	City		State	(Country	y)		YEAR GRADUATED:		
SIGNATURE OF APPLICANT:							DA	DATE:		
B. TO BE COMPLETED BY THE SCHOOL OF NURSING  The above applicant has applied for Public Health Nurse Certification in California. Please supply the following information and attach an official transcript.										
ENTRANCE DATE:				ATE DEGREE AWARDED:				TYPE OF DEGREE AWARDED:		
OUT-OF-STATE GRADUATES ONLY										
Is this sch	s this school NLN accredited? Yes No If yes,						when:			
Is this school CCNE accredited? Yes No						If yes, when:				
Was the school accredited at the time of applicant's graduation?  Yes							N	To		
		<u> </u>	-					<del>-</del>		
SIGNATURE OF SCHOOL OFFICIAL:							T)	TELEPHONE: ( )		
NAME & TITLE:							D	DATE:		