

**BOARD OF REGISTERED NURSING**

P O Box 944210, Sacramento, CA 94244-2100

TDD (916) 322-1700

Telephone (916) 322-3350

www.rn.ca.gov



**REQUEST FOR TRANSCRIPT
PUBLIC HEALTH NURSE CERTIFICATION**

A. TO BE COMPLETED BY APPLICANT

Send this form to your baccalaureate school of nursing (BSN). 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 unless received in a sealed envelope. Your public health training must meet California educational requirements.

NAME: Last	First	Middle	Previous Names (Including Maiden):
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ADDRESS: Street	City	State	Zip Code
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SOCIAL SECURITY NUMBER:	BIRTHDATE: Month Day Year	TELEPHONE NUMBER: Home: () Work: ()
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5. NAME OF PROFESSIONAL REGISTERED NURSING SCHOOL:	6. YEARS ATTENDED: _____ to _____
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7. LOCATION: City State (Country)	8. YEAR GRADUATED:
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SIGNATURE OF APPLICANT: _____ 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:	DATE DEGREE REQUIREMENTS MET:	DATE DEGREE AWARDED:
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OUT-OF-STATE GRADUATES ONLY

Is this school NLN accredited? Yes _____ No _____ If yes, when: _____

Was the school accredited at the time of applicant's graduation? Yes _____ No _____

SIGNATURE OF OFFICIAL: _____ TELEPHONE: () _____

NAME & TITLE: _____ DATE: _____

SEAL

NOTE: TRANSCRIPTS MUST BE SUBMITTED FOR ALL APPLICANTS EXCEPT FOR THOSE WHO HAVE COMPLETED A CALIFORNIA APPROVED BSN PRE-LICENSURE PROGRAM.