

Nurse Form 2F

Certification of Foreign Nursing Education

Use this form **ONLY** if your nursing school is located outside the United States or its territories and you were advised that CGFNS did not obtain full documentation needed for a New York State nursing license review of your CGFNS Credentials Verification Service for New York State Application or you are not utilizing the services of CGFNS.

Applicant Instructions

- Complete Section I. In item 4, enter your name exactly as it appears on your Application for Licensure (Form 1). **Be sure to sign and date item 9.**
- Have the professional school you attended complete the appropriate parts of Section II. Be sure to include any fee required by the school. The school of nursing must return the entire form in a sealed official school envelope along with an official transcript directly to the Office of the Professions at the address at the end of this form. If the transcript is not in English, a qualified translation is also required. For information on what constitutes a qualified translation, see our website <https://www.op.nysed.gov/about/general-information-policies#verif>. **This form and transcript will *not* be accepted if submitted by the applicant or any person or agency other than the proper school authority.**

Check what you are applying for (check one): ☐ Registered Professional Nurse ☐ Licensed Practical Nurse

Section I: Applicant Information

- Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)
- Birth Date Month Day Year
- Print Name Last
First
Middle
- 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.

- 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. Name as it appears on your Degree/Diploma/Certificate _____

8. Name of institution attended _____

Address of institution _____

Dates of attendance from mo. day yr. to mo. day yr.

Title of Degree/Diploma/Certificate awarded (in original language) _____

Date Degree/Diploma/Certificate awarded mo. yr. ☐ Not yet awarded

9. I request and give my permission to the institution listed in item 8 above to complete Section II of this form and mail it to the Office of the Professions 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.

Signature _____ Date _____

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

mo. day yr.

Date of completion

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 _____

Print Name _____

Title or official position _____

Institution _____

Address _____

Telephone _____

Fax _____

Email _____

Date _____

Institution Seal

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.