

SUPERINTENDENT'S VERIFICATION FOR INITIAL LICENSED PRACTICAL NURSE (LPN) LICENSURE

Applicant's Name _____

Social Security Number _____

Address _____

Street Address or Post Office Box

City, State, Zip Code

I, _____, hereby certify that I have verified that the
Printed Name of Superintendent or his/her Designee
above applicant:

- License needs to be issued for current School Year (SY)
- License needs to be issued for next School Year (SY)

_____ has earned a high school or high school equivalency diploma

_____ is at least eighteen (18) years of age,

_____ holds a current Certification in CPR;

_____ holds a current Certification in first aid;

_____ verification by the school superintendent that a local orientation related to assigned duties, and facilitated by the PED licensed registered nurse, was satisfactorily completed.

(Signature of Superintendent or his/her Designee) **Date:** _____

District / Private School / Charter School: _____