

WEST VIRGINIA STATE BOARD OF EXAMINERS FOR
LICENSED PRACTICAL NURSES

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VERIFICATION OF EMPLOYMENT

Name of Licensee: _____

Address of Licensee: _____

WV LPN License Number: _____ Last four of Social Security #: xxx-xx- _____

This is to verify that the above named individual has engaged in _____ **clock hours** for **(90 day limited license dates)**

90 day limited dates employee worked from: _____ **to** _____

Name of Facility/Agency: _____

Address of Facility: _____

Telephone Number of Facility: _____

Name of Individual Verifying Employment
(Type or Print)

Title

Signature of Individual Verifying Employment

Date

Subscribed and sworn to before me on this _____ day of _____, 20 _____.

My commission expires on the _____ day of _____, 20 _____.

Notary Public

SEAL