



# PROFESSIONAL LICENSURE

To be completed by applicant/employee: (For multiple licenses/certificates you may leave first/last name blank unless registered in a different name)

First Name	Last Name	Social Security #	DOB
State where licensed:	License #	License Type:	Expiration Date:
<b>To be completed by @WORK Medical Staff: (NOTE - You must enter the license/expiration data into the AS400 system)</b>			
Confirmation Method: Telephone: <input type="checkbox"/> State Web Site: <input type="checkbox"/> Nursys: <input type="checkbox"/>	Confirmed by:	Status (List status of privilege to practice in compact state)	Disciplinary Action
First Name	Last Name		
State where licensed:	License #	License Type:	Expiration Date:
<b>To be completed by @WORK Medical Staff: (NOTE - You must enter the license/expiration data into the AS400 system)</b>			
Confirmation Method: Telephone: <input type="checkbox"/> State Web Site: <input type="checkbox"/> Nursys: <input type="checkbox"/>	Confirmed by:	Status (List status of privilege to practice in compact state)	Disciplinary Action
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I hereby release @WORK Medical Services, its franchise companies, and any person completing this form and authorize them to release all information regarding my professional licenses/certificates and status.

Applicant/Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_