International Education Evaluations
records@myiee.org

REQUEST FOR LICENSE INFORMATION: NURSING

PART 1 | TO BE COMPLETED BY APPLICANT

Note to Applicant: It is your responsibility to ask the organization responsible for nursing licensure in the country you were educated/trained to verify your nursing license and/or registration for IEE. Please complete Page 1 and submit it to the appropriate agency, ministry, or government department. Note that some organizations may charge a fee for this service.

Last / Family Name	First / Given Name
Previous Name (if applicable)	Date of Birth (dd/mm/yyyy)
Issuing Organization	License / Registration Effective Date
License / Registration Number	Applicant's Email Address

I hereby authorize the release of my academic records to International Education Evaluations.

Applicant's Signature _____ **Date** _____

PART 2 | TO BE COMPLETED BY NURSE LICENSING AUTHORITY

Note to Authorized Official: The above-named person seeks to have their nursing credentials evaluated and requests that information pertinent to their foreign license and/or registration be released to IEE. Please complete and sign this form and return to IEE (preferably via official email). *Please do not send the form to the nurse who has requested the information; IEE will not accept forms returned via third parties.*

Name of Official Completing Form	Title	
Street Address		URL www.
City	Country	Postal Code
Telephone	Fax	Email

PART 2 | (continued)

Information about this Nurse License

Legal / Professional Title on License		Date of Initial Issue / Effective Date
Date of Expiration	License/Registration Number	Renewal Dates (if appropriate)

Eligibility Requirements for Licensure – check all that apply:

- ☐ Successful completion of a recognized nursing education program
- ☐ Successful completion of a nursing licensure examination

Disciplinary Action/Sanctions or License Revoked?

- ◯ NO / NONE
- ◯ YES (if YES, please explain)

Function - License gives access to employment as a (check all that apply)

- ☐ Registered Nurse
- ☐ Licensed Practical / Vocational Nurse
- ☐ Other (identify): _____

Authorized Official's Signature _____ **Date** _____

[and seal, if appropriate]

RETURN TO IEE

Submit electronically (preferred)

records@myiee.org

Email will only be accepted from verified organizational addresses with official domain names.

Submit via post

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