



# ALABAMA BOARD OF NURSING

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## GRADUATE NURSING SCHOLARSHIP: VERIFICATION OF EMPLOYMENT

**INSTRUCTIONS: THIS FORM IS TO BE COMPLETED BY THE EMPLOYER OR AN AUTHORIZED AGENT OF THE EMPLOYER.**

I CERTIFY THAT \_\_\_\_\_ WAS EMPLOYED  
NAME OF NURSE / SCHOLARSHIP RECIPIENT

FULL-TIME AS A NURSING INSTRUCTOR AT:

\_\_\_\_\_  
NAME AND ADDRESS OF EMPLOYER (COLLEGE OR UNIVERSITY)

FOR THE PERIOD \_\_\_\_\_ TO \_\_\_\_\_  
MONTH AND YEAR MONTH AND YEAR

\_\_\_\_\_  
SIGNATURE OF EMPLOYER OR  
AGENT OF EMPLOYER

\_\_\_\_\_  
PHONE/FAX

\_\_\_\_\_  
DATE