Alabama Board of Nursing
SCHOLARSHIP PROGRAM
Semi - Annual
Employment Verification

Do not leave blanks. Submit form on July 14 and January 14.

SCHOLARSHIP RECIPIENT

Year:_____ Half: ☐ Jan–Jun ☐ Jul-Dec

Name:

Address:

City: **State:** **Zip:**

Email:

Best Phone Number:

I certify that I am serving at the site listed on the right.

Signature:_____

Nursing License Number:_____

Date:_____

IMPORTANT INFORMATION

All scholarship recipients are required to work as a professional nurse or a nursing instructor for a minimum of two years in the state of Alabama.

*This verification form is due in our office no later than close of business on July 14 and January 14.

EMPLOYER SECTION

Site Name:

Address:

City: **Zip:**

I have reviewed the hours worked and certify that the scholarship recipient: *(check all that apply*ÝÝ

Was employed at this site for the dates indicated and **WORKED:**

☐ In the capacity of a professional nurse

☐ In the capacity of a nursing instructor

☐ Is/was on extended leave from _____ to _____ due to _____.

The certifications and information provided above are true, accurate and complete to the best of my knowledge and belief.

Signature:

Printed Name:

Title:

Date:

Phone Number:

Email:

The administrator (not the recipient) may mail, fax, or scan and email the service form to:

Mail: ABN PO Box 303900 Montgomery, AL 36130-3900 **Fax:** 334-293-5201 **Email:** [illegible]@abn.alabama.gov **Phone:** 334-293-5200