

OKLAHOMA BOARD OF NURSING

**2915 N. Classen Blvd., Suite 524
Oklahoma City, Oklahoma 73106
405/962-1800**

FACULTY QUALIFICATION RECORD

A Faculty Qualification Record shall be submitted for all instructional staff (full-time, part-time, classroom, or clinical), and shall include educational preparation and employment experience. The Faculty Qualification Record shall be submitted within two weeks following the appointment by the Nurse Administrator on a form provided by the Board [485:10-3-5 (1)]. A new Faculty Qualification Record shall be submitted anytime that an advanced degree is attained [485:10-5-5.2 (e-3)].

Name of Nursing Program _____ City _____

Full Licensure Name _____

Oklahoma License # _____ Date of Appointment _____ Full Time or Part-Time

Title of Position: _____ Areas of Teaching Responsibility: _____

Educational Preparation*

	Name of School	City & State	Graduation Date		Degree
			Month/Year	Major	
Basic Nsg. Education	_____	_____	_____	_____	_____
Advanced Education	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

***Please attach copies of official transcripts on file at the employing institution.**

Previous Employment** Begin with last position held. Evidence must be provided of a minimum of two (2) years full-time equivalent practice as a Registered Nurse in a clinical setting.

Dates of Employment (Month/Year)	Employer	City & State	Position	FTE (in Years)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**** These sections must be completed even if a curriculum vitae and transcripts are attached.**

I certify that I am the faculty member who is referred to in the foregoing *Faculty Qualification Record* and that the statements therein contained are true in every respect. I certify that I have met the requirements established in the *Oklahoma Nursing Practice Act and Rules* for nursing faculty, including requirements for Oklahoma licensure, level of education, and clinical experience [§567.12 (B) and 485:10-5-5.2].

Signature of Faculty Member

Date

I certify that I have verified the Oklahoma nursing license of the faculty member. In addition, I have reviewed the official transcripts and work experience, and have verified that the faculty member meets the qualifications of the *Oklahoma Nursing Practice Act and Rules*.

Signature of Nurse Administrator

Date