Matthew H. Mead
Governor

Wyoming
STATE BOARD OF NURSING

Cynthia LaBonde MN, RN
Executive Director

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Mailing List Order Form (Pages 1 and 2 must be completed and submitted)

Agency/Institution:	Address:		
City:	State:	Zip:	Phone:
E-Mail Address (where the list should be sent) :			

____hereby agrees that the names and addresses of the nurses maintained and provided by the Wyoming State Board of Nursing will be used for the following specific purpose:____
____

NOTE: Cost is based on number of licensees x $.05. Lists are provided via e-mail only. Please submit both pages 1 and 2 for a price quote at: wsbn-info-licensing@wyo.gov The list will be prepared as of the date of the quote and will be released to the requestor as soon as all funds are received. *Lists are available for individual counties, specific degrees, etc.

$.05 per Licensee/Certificate Holder - Minimum Charge: $25.00

Advanced Practice Registered Nurses (APRNs)	**Date Quote Given:**	$
Registered Nurses	**Date Quote Given:**	$
Licensed Practical Nurses	**Price Quote Given:**	$
Certified Nursing Assistants	**Price Quote Given:**	$
All License/Certificate Types	**Price Quote Given:**	$

Quote By:	**Special Instructions:**

Mandatory **$5.00** processing fee for all VISA, MasterCard or Discover requests	Processing Fee	$
If requesting specific counties, please list:	Total Amount Due	$

It is agreed that the cost of providing such information will be borne by the requester and paid in advance. Acceptable forms of payment: Business Check, Cashier's Check, Money Order, VISA, MasterCard or Discover. No personal checks or cash. The names and addresses will not be used for any other purpose other than that stated in this Agreement and that the names and addresses will not be released to any other individual, group or agency. The materials/publications to be disseminated shall not be published in any manner which could be construed by the public to mean that the Wyoming State Board of Nursing supports, endorses, or approves the materials/publications to be disseminated.

Signature

Card Holder Name, Address and Phone Number (PLEASE PRINT):

☐Visa ☐MasterCard ☐Discover	Card Number and Three Digit Security Code (on back of card): ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ Security Code: ☐☐☐	Expiration Date: ☐☐☐☐

By signing below I authorize WSBN to charge my credit card for the total amount indicated above:

Signature:____Date:_____________________

Mission: Serve and safeguard the people of Wyoming through the regulation of nursing education and practice.

Wyoming State Board of Nursing

Mailing List Order Form

Submitted By:____ Date:_____________

Organization:____

City:____ State: _________________________

Phone (required):____Email (required): ___________________________________

SOCIAL SECURITY NUMBERS (SSN) and BIRTHDATES WILL NOT BE PROVIDED PER WSBN POLICY.

Check Appropriate Licensure Type:

APRN RN LPN CNA

CUSTOM REPORT: Check Appropriate Box

- ☐ License Type
- ☐ Initial
- ☐ License Number
- ☐ APRN
- ☐ APRN Num
- ☐ APRN Issue
- ☐ Issue Date
- ☐ Email Address
- ☐ Inactive Date
- ☐ Expiration Date
- ☐ Last Name
- ☐ First Name
- ☐ Middle Name
- ☐ Maiden Name
- ☐ Address1/Address 2
- ☐ City/State/Zip/Zip Suffix
- ☐ County
- ☐ Region
- ☐ Gender (Male/Female)
- ☐ APRN RX
- ☐ Nursing Degree (if available)
- ☐ Highest Degree (if available)
- ☐ Current Employer
- ☐ Current Employer Address
- ☐ Current Employer City/State/Zip
- ☐ APRN Certifications
- ☐ APRN Recognitions
- ☐ Primary Employment Setting
- ☐ Primary Employment Position
- ☐ Primary Employment Specialty
- ☐ Primary Employee State
- ☐ Other____________________________(if available)
- ☐ Other____________________________(if available)