VERIFICATION OF COMPLETION FROM A WYOMING APPROVED NURSE AIDE TRAINING, COMPETENCY, AND EVALUATION PROGRAM (NATCEP)

Program Name:		Phone #:		**Lecture Hours:**	
Program Number:		Fax #:		**Skill Hours:**	
Mailing Address:		Email address		**Clinical Hours:**	
City, State, Zip:		**Date of Course Completion:**		**Total Hours:**	

This is to verify that the following individuals have successfully met the requirements for completion of the Nurse Aide Training, Competency, and Evaluation Program.

SOCIAL SECURITY #	Student Name		STUDENT MAILING ADDRESS
	(Last name)	(First name)	(Street, City, State, Zip Code & Phone)

*** Social Security Number required by Wyoming Statute 33-1-114. If the student does not have a social security numberm the WSBN can NOT issue a temporary permit or certification.**

Printed Name of Approved Program Director or Primary Instructor:			Signature of Approved Program Director or Primary Instructor:

Subscribed and sworn to before me this _____ day of _____, 20 ____.

_____ **Please have Notorized before sending into WSBN office.** [SEAL]

(Notary)

Applicants are not eligible for a GPN or Certification unless this form is completed in its entirety and a completed application and fees are received by the WSBN. If you have questions please call 307-777-7601.
This form must be received by the Wyoming State Board of Nursing **within 5 working days** of course completion. Email to wsbn-info-licensing@wyo.gov or mail to office.
Wyoming State Board of Nursing, 130 Hobbs Avenue, Suite B, Cheyenne, WY 82002