Iowa Board of Nursing
400 SW 8th Street Suite B
Des Moines, IA 50309-4685

REQUEST FOR OFFICIAL TRANSCRIPT
Formal Advanced Practice Educational Program
(Please forward this form directly to your advanced practice program)
TRANSCRIPTS ARE NOT ACCEPTED BY FAX OR ELECTRONICALLY.
This form NOT required if you are requesting the transcripts online from your school or by phone.

Name: _____
Last First Middle Maiden

Any other last names used: _____

Address of Requesting Individual:

_____

_____
City State Zip Code

Social Security Number: _____ Date of Birth: _____

Year of program completion:_____

Please send an official nursing transcript that verifies the date of completion of the program/graduation in a specialty area and the degree conferred.

_____
Name and Location of Nurse Practitioner Program Attended

to:

Iowa Board of Nursing
400 SW 8th Street Suite B
Des Moines, IA 50309-4685

_____
Signature of Requesting Individual Date

REGISTRAR: **Please attach this form to the official nursing transcript being sent to the Iowa Board of Nursing.**

This information is collected pursuant to IAC 7.2(3)a and 7.2(4)c. Failure of the requesting individual to provide this information will result in licensure denial. This information may be disclosed pursuant to IAC 655 – Chapter 11.