STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

BOARD OF REGISTERED NURSING
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BREAKDOWN OF EDUCATIONAL PROGRAM FOR INTERNATIONAL NURSING PROGRAMS

PRINT OR TYPE

STUDENT'S LAST NAME:	FIRST NAME:	MIDDLE NAME:

DATE OF BIRTH: *(Month/Day/Year)*	PREVIOUS NAMES: *(Including Maiden)*	HIGH SCHOOL GRADUATION: *(Year)*

NAME AND LOCATION OF PROFESSIONAL REGISTERED NURSING SCHOOL:	
ENTRANCE DATE:	GRADUATION DATE:

All of the information requested on this form must be submitted including complete official transcript(s) along with the course description(s)** stated below. Failure to submit all requested documents will result in application processing delays.

	COURSE NUMBER or TITLE	THEORY HOURS OF INSTRUCTION (Total Hours)	SKILLS, LAB or SIMULATION HOURS OF INSTRUCTION AT SCHOOL (Total Hours)	CLINICAL PRACTICE HOURS OF INSTRUCTION IN HOSPITAL (Total Hours)
WRITTEN & ORAL COMMUNICATIONS				
GENERAL PSYCHOLOGY				
SOCIAL SCIENCE				
ANATOMY & PHYSIOLOGY				
MICROBIOLOGY				
MEDICAL NURSING **				
SURGICAL NURSING **				
OBSTETRIC NURSING				
PEDIATRIC NURSING				
PSYCHIATRIC NURSING				

** **Send course description(s) attached to this form showing evidence of geriatric content in these nursing areas. Failure to submit course description(s) will result in delays in processing the application.**

SIGNATURE OF SCHOOL OFFICIAL: _____ **DATE:** _____

TITLE: _____

(SCHOOL OR HOSPITAL SEAL/STAMP)