Reset Form

**CERTIFICATE OF COMPLETION**
**NURSING**
State Form 50024 (R10 / 2-26)

**INDIANA STATE BOARD OF NURSING**
**PROFESSIONAL LICENSING AGENCY**
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Indianapolis, Indiana 46204
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# CERTIFICATE OF COMPLETION

☐ **REGISTERED NURSE (RN)** ☐ **LICENSED PRACTICAL NURSE (LPN)**

**Program Type:** ☐ **Certificate** ☐ **Diploma** ☐ **Associate** ☐ **Baccalaureate** ☐ **Master's Direct Entry**

*I hereby certify that* _____ *was admitted*
*(First Name/ Middle Name / Last Name)*
*to the* _____ *Program*
*(School Name and Program type)*
*of Nursing located in* _____ *on* _____
*(City, State)* *(Enrollment Date MM/DD/YYYY)*
*and successfully completed program requirements for graduation on* _____
*(Completion Date MM/DD/YYY)*
*Applicant will/did graduate on* _____ *. His/Her Social Security number is*
*(Graduation Date MM/DD/YYYY)*
_____.
*SSN (XXX-XX-XXXX)*

*I attest that the factual statements contained in the information provided on this Certificate of Completion are within my personal knowledge and are true and correct. There is evidence in our permanent records that this person has met the requirements as specified in Indiana law.*

*DATE:* _____ *SIGNED:* _____
*(Date Verified MM/DD/YYY)* *Signature*

_____
*Printed Name*

_____
*Dean / Director / Designee*

*SCHOOL SEAL*

***APPLICANT:*** *The* ***CERTIFICATE OF COMPLETION*** *form must be completed and sent to the Professional Licensing Agency by your program of nursing. You will not be declared eligible to take the examination until this form is received by the Agency.*

***DIRECTOR OF PROGRAM:*** *The applicant cannot be declared eligible to take the examination until this form is received by the Professional Licensing Agency.* ***CERTIFICATES OF COMPLETION SHOULD NOT BE SENT TO THE PROFESSIONAL LICENSING AGENCY UNTIL THE APPLICANT HAS COMPLETED THE PROGRAM OF NURSING.***
***Must sign and date AFTER the applicant has completed all requirements for graduation.***