

Office of Professional Regulation
Vermont Board of Nursing

**Advanced Practice Registered Nurse
Attestation Form
Completion of Transition to Practice Requirement**

*** Fill out and submit one form for each certification you hold. On each form, indicate whether you have practiced the required number of hours to fulfill the transition to practice requirement (2400 hours and two years for primary credential; 1600 hours and 1 year for secondary credential)**

Name: _____ DOB ____/____/____

License #: _____

Certification: _____
(eg: FNP, ANP, PNP, CNM, CRNA,
PMHNP (family, adult, child/adolescent);
Psychiatric CNS (family, adult. child/ adolescent)

Date certification first issued: ____/____/____
(month / year)

Total Number of collaborative practice hours completed: _____

Dates of practice that led to completion of transition to practice hours:
____/____/____ to ____/____/____

***I certify under the pains and penalties of perjury, that all information I have provided in this document is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in action against me. (The maximum penalty for perjury is fifteen years in prison and/or \$10,000 fine. 3 V.S.A. §2901)**

Signed: _____
Signature Date

PRINT name of signature

Send completed form to: Vermont Board of Nursing
Office of Professional Regulation
National Life Building, North, Floor 2
Montpelier, VT 05620-3402