



COMMONWEALTH BOARD OF NURSE EXAMINERS
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CERTIFICATION OF RELATED LEARNING EXPERIENCE

NAME: _____

NAME OF COLLEGE
 OR UNIVERSITY ATTENDED: _____

DEGREE OBTAINED: _____

DATE OF GRADUATION: _____

**BREAKDOWN OF CLINICAL NURSING PRACTICE EXPERIENCE, AS
 STIPULATED IN NURSING COURSES:**

SUBJECT AREA	CLINICAL PRACTICE (how many hours in a week x how many weeks)	TOTAL CLINICAL PRACTICE EXPERIENCE (show in hours & weeks)
MEDICAL NURSING		
SURGICAL NURSING		
PEDIATRIC NURSING		
OBSTETRIC NURSING		
PSYCHIATRIC NURSING		

Certified By: _____
 Registrar or Dean of College of University

(Affix Official Seal Here)

Date: _____