Pediatric Nursing Certification Board, Inc.
Verification of Clinical Practice Hours

To be used only if you selected the clinical practice hours' option for recertification.

Certificant Name _____

Last 4 Digits of Social Security Number _____

To be completed by a supervisor who can verify your nursing clinical practice hours.

I attest that _____ practiced _____ hours
(Name of Nurse)

at _____ from _____ through _____
(Name of Clinical Setting)

Supervisor's Signature _____

Supervisor's Title _____

Supervisor's Contact Email or Phone Number _____

Date Signed _____

The above signature attests to the accuracy of the above practice statement.