
**Oglala Lakota College-Department of Nursing**

**Preceptor Credentialing Verification**

(To be completed by Personnel Office, Director of Nursing, or Supervisor of Department of employing facility)

I, _____, hereby verify that

_____, RN does in fact have a copy of an active

Nursing License for the State of _____, on file in our Personnel Office/Files.

_____,_____

*Authorized Verifier* *Position*

Date:_____