Certification of Language Proficiency
• To be submitted with the Registered Nursing Application

Instructions:
Please complete the following form to meet the criteria for Category 8: Native Speaker

• To be completed by student •

Name: ____________________________________________ Phone: ________________________________

Student Certification of Proficiency

Language: ____________________________________________

English is: □ First Language □ Second Language

• To be completed by Professor, Clergy Member, or Supervisor •

( NOT A CLOSE FRIEND/RELATIVE )

How long have you known the student and in what capacity?
__________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________

How often have you observed the student conversing/ translating in this language?
☐ Daily □ 3+ days per week □ 1+ days per week

• Please rate the student on a scale from 1 (low) to 5 (high) •

Student’s proficiency in speaking this language: 1 2 3 4 5
Student’s proficiency in writing this language: 1 2 3 4 5
Student’s proficiency in reading this language: 1 2 3 4 5

I certify that I am fluent in the identified foreign language as listed above and that I have observed the listed student and his/her language skills within the past year.

Signature: ____________________________________________ Date: ____________________________________________