



2829 University Avenue SE #200
 Minneapolis, MN 55414-3253
 (612) 317-3000 – Voice (612) 617-2190 – Fax
 Toll Free (888) 234-2690 (MN, IA, ND, SD, WI)
 (800) 627-3529 – TTY
 Email: nursing.board@state.mn.us
 Website: www.nursingboard.state.mn.us

CONFIRMATION OF NURSING EMPLOYMENT FOR LICENSURE BY ENDORSEMENT

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements.

Until you are issued a license, all data submitted on the application, except your name and address, are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the application become public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

- Type or print clearly
- Use black ink
- Provide all information
- Incomplete forms will be returned
- Do not use initials or abbreviations

APPLICANT INFORMATION				
LAST NAME		FIRST NAME		MIDDLE NAME
				<input type="checkbox"/> No middle name
DATE OF LAST NURSING PRACTICE (mm/dd/yyyy)		TYPE OF PRACTICE		BIRTH DATE (mm/dd/yyyy)
		<input type="checkbox"/> Employed in nursing <input type="checkbox"/> Volunteer nursing		
STREET ADDRESS <input type="checkbox"/> Home <input type="checkbox"/> Business		CITY	STATE PROVINCE	ZIP/POSTAL CODE
				COUNTRY
LEGAL SIGNATURE OF APPLICANT				DATE (mm/dd/yyyy)

- **SEND THIS FORM TO AN EMPLOYER FOR WHOM YOU HAVE WORKED AS A NURSE.** If you did not have an employer, a patient, volunteer supervisor, patient's family or physician, or a peer may verify nursing practice. This form must verify your most recent date of nursing practice.

NURSING PRACTICE	
↓Applicant: Do not write below this line.↓	
NOTE: Verify this person's practice as nursing practice only if the person was employed or volunteered as a licensed registered nurse or licensed practical nurse or if the position required a license as a nurse.	
This person:	<input type="checkbox"/> was employed as a nurse last date of practice as a nurse (mm/dd/yyyy): _____ <input type="checkbox"/> volunteered as a nurse last date of practice as a nurse (mm/dd/yyyy): _____ <input type="checkbox"/> is currently employed as a nurse. last date of practice as a nurse (mm/dd/yyyy): _____ If the nurse is currently employed, this date must be filled in. Please do not write "Current."
This person practiced as a:	<input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical/Vocational Nurse
State in which practice occurred: _____	
NAME OF INSTITUTION OR AGENCY	FEDERAL FACILITY/AGENCY <input type="checkbox"/> Yes <input type="checkbox"/> No
STREET ADDRESS	CITY, STATE, ZIP CODE
SIGNATURE	DATE (mm/dd/yyyy) TITLE

Return completed form to Minnesota Board of Nursing