



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

**ADVANCED PRACTICE REGISTERED NURSE LICENSURE APPLICATION**

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. Minnesota Statute Sec. 270C.72 requires applicants to provide their Social Security number and Minnesota business identification number on all license applications.

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, except social security number and responses to grounds for review questions, becomes 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 applications will be returned •Do not use initials or abbreviations

APPLICANT INFORMATION											
LAST NAME				FIRST NAME				MIDDLE NAME			
								<input type="checkbox"/> No middle name			
MAIDEN NAME				OTHER LAST NAME(S)				PHONE NUMBER <input type="checkbox"/> Home <input type="checkbox"/> Business ( )			
STREET ADDRESS											
CITY				STATE/PROVINCE				ZIP/POSTAL CODE		COUNTRY	
EMAIL ADDRESS											
MINNESOTA LICENSE NUMBER <input type="checkbox"/> RN _____				BIRTH DATE (mm/dd/yyyy)				GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female			
UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72				<input type="checkbox"/> I do not have a US Social Security number at this time but will notify the Board if/when I obtain a US Social Security number				MINNESOTA BUSINESS IDENTIFICATION NUMBER Required by Minn. Stat. Sec. 270C.72			
APRN PROGRAM NAME								COMPLETION DATE (mm/dd/yyyy)			
BUSINESS ADDRESS: Minn. Stat. Sec. 214.073 requires licensees to provide their primary business address (if employed as a nurse) at the time of initial application and all renewals. Your license will not be issued unless you provide it or check the box below certifying that you are not currently in the workforce related to your practice.											
<input type="checkbox"/> I certify that I am not currently in the workforce related to my practice and I don't have a business address related to my practice.											
<b>APRN ROLE</b> (A separate application is required for each role)											
<input type="checkbox"/> NURSE PRACTITIONER				<input type="checkbox"/> NURSE MIDWIFE							
<input type="checkbox"/> NURSE ANESTHETIST				<input type="checkbox"/> CLINICAL NURSE SPECIALIST							
<b>POPULATION FOCUS</b> (Check all statements that apply)											
<input type="checkbox"/> ADULT GERONTOLOGY				<input type="checkbox"/> PEDIATRIC				<input type="checkbox"/> ACUTE CARE (if appropriate)			
<input type="checkbox"/> NEONATAL				<input type="checkbox"/> HEALTH PSYCHIATRIC/MENTAL				<input type="checkbox"/> PRIMARY CARE (if appropriate)			
<input type="checkbox"/> WOMEN'S HEALTH				<input type="checkbox"/> FAMILY							

**CURRENT CERTIFICATION**

**Applicant must request documentation of current certification in good standing be sent directly from the certifying body to the Board.**

CERTIFYING ORGANIZATION	CERTIFICATION TYPE	EFFECTIVE DATE	EXPIRATION DATE
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**PRESCRIBING**

PRESCRIBING PHARMACOLOGICAL INTERVENTIONS (MEDICATIONS)	<input type="checkbox"/> YES <input type="checkbox"/> NO
PRESCRIBING NON-PHARMACOLOGICAL INTERVENTIONS (X-RAYS, LABS, THERAPIES, ETC.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
DEA NUMBER	STATE ISSUED
DEA NUMBER	STATE ISSUED

**GROUND FOR REVIEW OF APPLICATION**

**Provide a written explanation for every Yes response.**

- Have you ever violated a state or federal law or rule relating to the practice of nursing in any state, territory or country?  
 Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 No.
- Have you ever violated a state or federal law or rule relating to narcotics or controlled substances or other similar regulations?  
 Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 No.
- Have you ever been convicted, entered a plea of guilty, *nolo contendere*, or no contest, for any felony, gross misdemeanor or misdemeanor offense? *NOTE: The fact that a conviction has been pardoned, expunged, dismissed, stayed, or deferred, or that your civil rights have been restored, does not mean that you answer "NO"; you should answer "YES."*  
 Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 No.
- In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent?  
 Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 No.
- Have you been fired from a nursing-related job in the last five years due to conduct that may be grounds for disciplinary action under the Nurse Practice Act?  
 Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 No.
- Are you under investigation or are you the subject of any pending or past disciplinary action or have you ever been refused a nursing license or any other occupational license in any state, territory or country?  
 Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 No.
- Do you have any physical or mental disability or illness that may impair your ability to practice nursing with reasonable skill and safety?  
*NOTE: If you are currently participating in the Health Professionals Services Program (HPSP) for this illness, you may answer "NO" to this question.*  
 Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a statement explaining management and treatment is attached.  
 Yes, this has previously been reported by me to the Minnesota Board of Nursing and a statement explaining management and treatment is attached.  
 No.
- Have you ever received notification from the Minnesota Department of Human Services or the United States Department of Health and Human Services, Office of the Inspector General that you have been disqualified from providing direct care or excluded from participation in Medicare or Medicaid?  
 Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.  
 No.

I affirm that the statements and documents provided by me during the application process are true and correct.

\_\_\_\_\_  
Legal Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)



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**CONFIRMATION OF GRADUATION - ADVANCED PRACTICE REGISTERED NURSE**

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 licensed, all data submitted on this form, 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 form becomes 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.

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<b>APPLICANT INFORMATION</b>		
Complete the applicant information. If you do not have a graduate education as an APRN in one of the four roles and one of the six population foci, check the appropriate box and verify that you were recognized by the Minnesota Board of Nursing to practice as an APRN on July 1, 2014. This means that the Board had a current copy of your certification as an APRN. Sign and date the document. The <i>Affidavit Section</i> is to be completed by the school official of the APRN program you attended. Mail the document to the appropriate APRN program.		
LAST NAME	FIRST NAME	MIDDLE NAME <input type="checkbox"/> No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER <input type="checkbox"/> Home <input type="checkbox"/> Business (   )
MINNESOTA LICENSE NUMBER <input type="checkbox"/> RN _____		BIRTH DATE (mm/dd/yyyy)
APRN PROGRAM NAME (School name, no initials)		
CITY AND STATE OF APRN PROGRAM		GRADUATION DATE (mm/dd/yyyy)
<input type="checkbox"/> I authorize _____ (name of APRN program) to release my educational dates to the Minnesota Board of Nursing.		
<input type="checkbox"/> I do not meet the requirements for completion of graduate level education as an APRN in one of the four APRN roles and population focus. <input type="checkbox"/> I was recognized by the Board to practice as an APRN prior to and on July 1, 2014.		
_____ Legal Signature		_____ Date (mm/dd/yyyy)

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**Applicant:** Complete the *Applicant Information* section above and forward to your school of nursing for completion. If the school official is not able to verify completion of all requirements, contact the Board of Nursing for further instructions.

**AFFIDAVIT SECTION**

**↓ This Section for School Use Only - Applicant: Do Not Write Below This Line ↓**

This form must be mailed directly from the school to the Minnesota Board of Nursing. The Board does not accept faxed or emailed Confirmation of Program Completion forms.

**SCHOOL OFFICIAL:** Complete Affidavit Section after the above named applicant has fulfilled all the requirements of the nursing program and is eligible for graduation.

**PROGRAM INFORMATION**

Was the APRN program at a graduate level? YES  NO

**ROLE PREPARATION:**

Nurse Practitioner       Registered Nurse Anesthetist       Clinical Nurse Specialist       Nurse Midwife

**POPULATION FOCUS:**

Adult-Gerontology       Family and Individual       Neonatal       Pediatric       Women's and Gender Health

Psychiatric and Mental Health

Acute (if applicable)

Primary (if applicable)

Is the program accredited by a national nursing accrediting agency? YES  NO

Is approval of the nursing program required by the Board of Nursing? YES  NO

Name of the Board of Nursing granting program approval \_\_\_\_\_

NAME OF ACCREDITATION BODY

DATES OF CURRENT ACCREDITATION  
(mm/dd/yyyy-mm/dd/yyyy)

**DEGREE TYPE**

Doctorate of Nursing Practice  
 Masters  
 Other (explain) \_\_\_\_\_

GRADUATION DATE (mm/dd/yyyy)

The undersigned does hereby affirm that the information provided is true and correct.

\_\_\_\_\_  
Signature of School Official

\_\_\_\_\_  
Name and Title (Dean, Program Director or Institutional Registrar's Office) (print)

Affix School Seal or Stamp

School Official: Return completed form to Minnesota Board of Nursing