MINNESOTA BOARD OF NURSING

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Email: nursing.board@state.mn.us
Website: www.nursingboard.state.mn.us

CONFIRMATION OF ADVANCED PRACTICE REGISTERED NURSE EMPLOYMENT

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine eligibility for reauthorization of your APRN license; enable us to contact you when necessary; and identify you. All data submitted on the application is a 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 • Provide all information • Incomplete forms will be returned • Do not use initials or abbreviations

APPLICANT INFORMATION

LAST NAME	FIRSTNAME	MIDDLE NAME ☐ No middle name
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
MINNESOTA LICENSE NUMBER ☐ APRN _____ ☐ RN _____		BIRTH DATE (mm/dd/yyyy)
E-MAIL ADDRESS		
LAST DATE OF ADVANCED PRACTICE REGISTERED NURSE PRACTICE (mm/dd/yyyy) ☐ I have not worked as an APRN		
TYPE OF PRACTICE ☐ Employment as APRN ☐ Volunteer as APRN	If it has been more than five years since you completed an APRN Program and you have not practiced as an APRN you will need to complete a Board approved reorientation plan upon licensure. Please contact the Minnesota Board of Nursing for more information.	
LEGAL SIGNATURE OF APPLICANT		DATE (mm/dd/yyyy)

SEND THIS FORM TO AN EMPLOYER OR CONTRACTOR FOR WHOM YOU HAVE WORKED AS AN APRN

- If employed or contracted by an institution or agency, an employer or contractor must complete the form.
- If employed by a patient, a patient's family member or significant other must complete the form.
- If you volunteered, the volunteer supervisor must complete the form.
- If the employer is no longer in business, the party responsible for providing employment verifications for the employer must complete the form.

ADVANCED PRACTICE REGISTERED NURSE PRACTICE

To be completed by employer

NOTE: Verify this person's practice as an APRN if the person was employed or volunteered as an APRN and if the position required an APRN license. The date field must be completed in mm/dd/yyyy format. Do not write "Current".

This person:

☐ was employed as an APRN in the role of ☐CNM ☐CNP ☐CNS ☐CRNA

☐ volunteered as an APRN in the role of ☐CNM ☐CNP ☐CNS ☐CRNA

☐ is employed as an APRN in the role of ☐CNM ☐CNP ☐CNS ☐CRNA

Last date of practice (mm/dd/yyyy): _____

State in which practice occurred: _____

POPULATION FOCUS (Check all statements that apply)

☐ ADULT GERONTOLOGY
☐ NEONATAL
☐ PEDIATRIC
☐ HEALTH PSYCHIATRIC/MENTAL
☐ FAMILY
☐ WOMEN'S HEALTH
☐ ACUTE CARE (if appropriate)
☐ PRIMARY CARE (if appropriate)

NAME OF INSTITUTION, AGENCY, OR CONTRACTOR	FEDERAL FACILITY/AGENCY ☐Yes ☐ No
STREET ADDRESS	CITY, STATE, ZIP CODE

LEGAL SIGNATURE	TITLE	DATE (mm/dd/yyyy)