



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

Form with fields: LAST NAME, FIRSTNAME, MIDDLE NAME, STREET ADDRESS, CITY, STATE/PROVINCE, ZIP/POSTAL CODE, COUNTRY, MINNESOTA LICENSE NUMBER, BIRTH DATE, E-MAIL ADDRESS, LAST DATE OF ADVANCED PRACTICE REGISTERED NURSE PRACTICE, TYPE OF PRACTICE, LEGAL SIGNATURE OF APPLICANT, DATE

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".

Form with fields: This person: was employed as an APRN in the role of, volunteered as an APRN in the role of, is employed as an APRN in the role of; POPULATION FOCUS (Check all statements that apply); NAME OF INSTITUTION, AGENCY, OR CONTRACTOR; FEDERAL FACILITY/AGENCY; STREET ADDRESS; CITY, STATE, ZIP CODE; LEGAL SIGNATURE; TITLE; DATE