



CONFIRMATION OF PROGRAM COMPLETION - 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 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 applications will be returned • Do not use initials or abbreviations

APPLICANT INFORMATION
Complete the applicant information below, and fax, email or mail the two-page Confirmation of Program Completion form to the appropriate APRN program to complete the Affidavit Section. The APRN program will mail the completed two-page Confirmation of Program Completion form to the Board in an official school envelope.
LAST NAME FIRST NAME MIDDLE NAME
MAIDEN NAME OTHER LAST NAME(S) PHONE NUMBER
MINNESOTA LICENSE NUMBER BIRTH DATE
APRN PROGRAM NAME (School name, no initials)
CITY AND STATE OF APRN PROGRAM GRADUATION DATE
I authorize (name of APRN program) to release my educational dates to the Minnesota Board of Nursing.
Check the appropriate box below if applicable
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.
I was recognized by the Minnesota Board of Nursing to practice in Minnesota as an APRN prior to and on July 1, 2014, which means that you held a Minnesota RN license and the Minnesota Board of Nursing had a current copy of your certification as an APRN.
Legal Signature Date

AFFIDAVIT SECTION

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

This two-page form must be mailed directly from the school in an official school envelope to the Minnesota Board of Nursing. The Board does not accept faxed or emailed *Confirmation of Program Completion* forms.

SCHOOL OFFICIAL: Complete the *Affidavit Section* after the applicant has fulfilled all requirements of the nursing program and has graduated from the program.

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 (check all that apply):

Adult-Gerontology Family and Individual Neonatal Pediatric Women's and Gender Health
 Psychiatric and Mental Health Acute (if applicable) Primary (if applicable)

Completed graduate-level course in each of the following areas:

Advanced Physiology and Pathophysiology YES NO

Advanced Health Assessment YES NO

Pharmacokinetics and Pharmacotherapeutics of all Broad Categories of Agents YES NO

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.

Legal Signature of School Official

Print Name and Title (Dean, Program Director or Institutional Registrar's Office)

Affix School Seal or Stamp

SCHOOL OFFICIAL: Mail completed two-page form directly to Minnesota Board of Nursing in an official school envelope.