MINNESOTA
BOARD OF NURSING

1210 Northland Drive #120, Mendota Heights, MN 55120
Voice: 612-317-3000 | Fax: 651-688-1841 |TTY: 800-627-3529
Toll Free (MN, IA, ND, SD, WI): 888-234-2690
Email: nursing.board@state.mn.us
Website: www.nursingboard.state.mn.us

ADVANCED PRACTICE REGISTERED NURSE (APRN) LICENSURE APPLICATION INSTRUCTIONS

All APRNS must complete an *APRN Licensure Application* (online or paper), *Confirmation of Program Completion for Advanced Practice Registered Nurse* form, *Confirmation of Advanced Practice Nurse Employment form*, request *Verification of Certification,* and complete a *Criminal Background Check* if one was not completed within the last year with the Minnesota Board of Nursing.

APRN Licensure Application Requirements:

1. Complete one *APRN Licensure Application* form (online or paper) for each role (Clinical Nurse Specialist, Nurse Midwife, Nurse Practitioner, and Registered Nurse Anesthetist) for which you are applying once a Minnesota RN license has been obtained. A separate application form, fee and license are required for each role.

   a. Complete the *Minnesota Business Identification Number* section only if you own a Minnesota Business.

   b. Complete the *Business Name* Section if you are currently practicing as an RN, LPN, or APRN in Minnesota or any other state. If you are not currently practicing, check the box that you are not currently in the workforce.

   c. Check the appropriate population focus in the *Population Focus* section. More than one population may be selected based upon your certification(s). Check Acute Care or Primary Care only if your certification reflects this designation.

   d. Certification must be in one of the six populations; adult-gerontology, family and individual across the lifespan, neonatal, pediatrics, psychiatric and mental health, and women's and gender related health.

   e. Certifications in the adult or gerontology only population for those applicants who obtained certification prior to November 1, 2017, will be considered as certification in adult-gerontology and the individual will be deemed eligible for APRN licensure.

   f. Complete the fields regarding DEA numbers. Provide information for all DEA numbers you hold or check the box if you do not have a DEA number. Please contact the DEA office to determine if you should obtain a DEA number.

   g. Submit a written explanation for any "Yes" response in the *Grounds For Review of Application* section.

   h. Sign your legal name and date the application. (Electronic signatures are not acceptable)

   i. APRN Application Fees:

      1. Enclose the $137.00 ($105.00 application fee and $32.00 criminal background check fee) in the form of a money order or cashier's check payable to the Minnesota Board of Nursing with the completed application form to the Minnesota Board of Nursing if a background check has not been completed within the last year with the Minnesota Board of Nursing. Personal checks are not accepted.

      OR

      2. Enclose the $105.00 application fee in the form of a money order or cashier's check payable to the Minnesota Board of Nursing with the completed application form to the Minnesota Board of Nursing if a background check has been completed within the last year with the Minnesota Board of Nursing. Personal checks are not accepted.

2. Request documentation of your current certification in good standing be sent by mail to the Minnesota Board of Nursing at 1210 Northland Drive Suite 120, Mendota Heights, MN 55120 or email to nursing.board@state.mn.us. The certification must be received directly from the certifying body to the Board.

3. Complete the first page of the *Confirmation of Program Completion for Advanced Practice Registered Nurse* form and forward the two-page form by fax, email, or mail to the APRN program you completed. The APRN program must mail the two-page form directly to the Board in an official school envelope.

4. Complete the *Confirmation of Advanced Practice Registered Nurse Employment* form and return to the Minnesota Board of Nursing by fax, email, or mail. If you have not previously worked as an APRN, complete the applicant information of the form and check the box that you have not worked as an APRN. If it has been more than five years since you have practiced as an APRN or have completed the APRN program, you must complete a Board approved reorientation plan upon licensure. Please contact the Board for more information. Ensure all signatures are legal signatures. Electronic signatures are not acceptable.

5. Complete the Criminal Background Check (CBC) and fingerprinting process if you have not completed a background check with the Board of Nursing within the last year. The CBC program will send you a fingerprint packet by email when you submit your application. CBC Program contact: email criminal.background.check@state.mn.us or call 651-201-2822 if you have questions.
The fingerprinting and criminal background check requirement for licensure with the Minnesota Board of Nursing is independent of any other fingerprinting or background check you may have done in the past or will have done in the future. You must complete the Minnesota Board of Nursing background check process as instructed.

6. CNS and CNP applicants only must submit the *Post-Graduate Practice Verification* form**.** The applicant will confirm they are not initiating APRN practice upon licensure at this time, **or** are initiating practice at this time with the location of hospital or integrated clinical setting, **or** have completed the 2080 post-graduate practice hours. The completion of the 2080 post-graduate practice hours must be within the context of a collaborative agreement within a hospital or integrated clinical setting where APRNs and physicians work together **or** if the applicant was listed on the Minnesota APRN Registry as of 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. This form may be faxed, emailed, or mailed to the Board. Ensure all signatures are legal signatures. Electronic signatures are not acceptable.

7. CRNAs who practice nonsurgical pain management must complete the Verification of CRNA Written Prescribing Agreement form. This form may be faxed, emailed, or mailed to the Board. Ensure all signatures are legal signatures. Electronic signatures are not acceptable.

Additional Requirement for Applicants Educated Outside of the United States

8. Request a *Summary of Evaluation of Educational Credentials* report from the Commission on Graduates of Foreign Nursing Schools (CGFNS). CGFNS evaluates the advanced practice nursing education to determine equivalency to the education required in the same type of advanced practice nursing education program in the United States. Please email nursing.education@state.mn.us, to request contact information for the CGFNS Specialist responsible for processing the advanced practice nurse education summary reports.

Total Due: $137.00 in U.S. funds ($105.00 application fee and $32.00 criminal background check fee) if a background check has not been completed within the last year with the Minnesota Board of Nursing. Money order or cashier's check only. No personal checks. All fees are nonrefundable.
Total Due: $105.00 in U.S. funds ($105.00 application fee) if a background check has been completed within the last year with the Minnesota Board of Nursing. Money order or cashier's check only. No personal checks. All fees are nonrefundable.

MINNESOTA BOARD OF NURSING

1210 Northland Drive #120, Mendota Heights, MN 55120
Voice: 612-317-3000 | Fax: 651-688-1841 |TTY: 800-627-3529
Toll Free (MN, IA, ND, SD, WI): 888-234-2690
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, 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

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
EMAIL ADDRESS		
MINNESOTA LICENSE NUMBER ☐ RN _____	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female
UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72 ___ - ___ - ____	☐ 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)	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.	

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.

BUSINESS NAME (if employed as a nurse)		
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE

☐ 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.

APRN ROLE (A separate application is required for each role)

☐ CERTIFIED NURSE PRACTITIONER
☐ CERTIFIED NURSE MIDWIFE
☐ CERTIFIED NURSE ANESTHETIST
☐ CLINICAL NURSE SPECIALIST

POPULATION FOCUS (Check all statements that apply)

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

-OVER-

CURRENT CERTIFICATION

Applicant must request documentation of current certification in good standing be sent to the Minnesota Board of Nursing by mail to 1210 Northland Drive Suite 120, Mendota Heights, MN 55120 or email to nursing.board@state.mn.us directly from the certifying body to the Board. Certification in the adult- or gerontology- only population for those applicants who obtained certification prior to November 1, 2017 will be considered as certification in adult-gerontology and the individual will be deemed eligible for APRN licensure.

PRESCRIBING

DEA NUMBER	STATE ISSUED
☐ I do not have a DEA number	

GROUNDS FOR DENIAL

Provide a written explanation for every YES response.

1.	☐ Yes ☐ No	Have you ever violated a state or federal law or rule relating to the practice of nursing in any state, territory or country?
2.	☐ Yes ☐ No	Have you ever violated a state or federal law or rule relating to narcotics or controlled substances or other similar regulations?
3.	☐ Yes ☐ 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, dismissed, stayed, or deferred, or that your civil rights have been restored, does not mean that you answer "NO"; you should answer "YES."
4.	☐ Yes ☐ No	Are there currently any pending criminal charges against you in any jurisdiction for felony, gross-misdemeanor, or misdemeanor crimes? NOTE: If charges have been dismissed or resulted in a disposition disclosed in the prior question you may answer "NO."
5.	☐ Yes ☐ No	In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent?
6.	☐ Yes ☐ No	In the last five years of nursing-related employment, has any employer investigated, disciplined or terminated you for conduct that may be grounds for disciplinary action under the Nurse Practice Act?
7.	☐ Yes ☐ No	Are you under investigation by any licensing authority, or are you the subject of any pending or past disciplinary action involving your license(s), or have you ever been refused a nursing license or any other occupational license in any state, territory or country?
8.	☐ Yes ☐ No	Do you have any physical or mental disability or illness that currently impairs your ability to practice nursing with reasonable skill and safety? **Provide a statement explaining management and treatment**. NOTE: If you are currently participating in the Health Professionals Services Program (HPSP) for this illness, you may answer "NO" to this question
9.	☐ Yes ☐ 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?

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

Legal Signature of Applicant _____ Date _____

Return completed form and fees to Minnesota Board of Nursing

MINNESOTA BOARD OF NURSING

1210 Northland Drive #120, Mendota Heights, MN 55120
Voice: 612-317-3000 | Fax: 651-688-1841 |TTY: 800-627-3529
Toll Free (MN, IA, ND, SD, WI): 888-234-2690
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)

MINNESOTA
BOARD OF NURSING

1210 Northland Drive #120, Mendota Heights, MN 55120
Voice: 612-317-3000 | Fax: 651-688-1841 |TTY: 800-627-3529
Toll Free (MN, IA, ND, SD, WI): 888-234-2690
Email: nursing.board@state.mn.us
Website: www.nursingboard.state.mn.us

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 ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
MINNESOTA LICENSE NUMBER ☐ RN _____		BIRTH DATE (mm/dd/yyyy)
APRN PROGRAM NAME (School name, no initials)		
CITY AND STATE OF APRN PROGRAM		GRADUATION DATE (mm/dd/yyyy)

☐ 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 (mm/dd/yyyy)

-over-

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

_____ Affix School Seal or Stamp

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

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

MINNESOTA BOARD OF NURSING

1210 Northland Drive #120, Mendota Heights, MN 55120
Voice: 612-317-3000 | Fax: 651-688-1841 |TTY: 800-627-3529
Toll Free (MN, IA, ND, SD, WI): 888-234-2690
Email: nursing.board@state.mn.us
Website: www.nursingboard.state.mn.us

POST-GRADUATE PRACTICE VERIFICATION FOR CNP AND CNS

The information and evidence you are asked to provide on this form is authorized by Minnesota Statutes. The data you supply will used to verify completion of 2,080 hours of post-graduate practice for Nurse Practitioners and Clinical Nurse Specialists.

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 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

Complete the applicant information and one of the following sections; initiation of practice, affidavit of post-graduate practice completion, or verification of completion of post-graduate practice.

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
EMAIL ADDRESS		
MINNESOTA LICENSE NUMBER ☐ RN _____	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female

INITIATION OF PRACTICE

This section must be completed by an individual who has not completed the 2,080 post-graduate practice hours and is or is not initially entering into practice at this time as a Certified Nurse Practitioner or Clinical Nurse Specialist. If you are initiating practice, provide information about the hospital or integrated clinical setting in which you are initiating practice below.

☐ I am not initiating APRN practice upon licensure at this time.

☐ I am initiating APRN practice upon licensure at location below.

NAME OF HOSPITAL OR INTEGRATED CLINICAL SETTING			
STREET ADDRESS			
CITY	STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY

-over-

Complete the Affidavit of Post-Graduate Practice Completion section or the Verification of Completion of Post-Graduate Practice section.

AFFIDAVIT OF POST-GRADUATE PRACTICE COMPLETION

This section must be completed by an APRN who was listed on the Minnesota APRN Registry as of July 1, 2014.

I affirm that I have completed 2,080 hours of post-graduate practice and was listed on the Minnesota APRN Registry as of 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.

The undersigned does hereby affirm that the statements contained in this application are true and correct.

_____

Print Name

_____ _____

Legal Signature Date (mm/dd/yyyy)

- OR -

VERIFICATION OF COMPLETION OF POST-GRADUATE PRACTICE

This section must be completed by a Certified Nurse Practitioner or Clinical Nurse Specialist who has completed 2,080 hours within the context of collaborative agreement within a hospital or integrated clinical setting where advanced practice registered nurses and physicians work together to provide patient care. Report the actual completion date.

☐ I have completed 2,080 hours of APRN practice within the context of a collaborative agreement within a hospital or integrated clinical setting

_____

Completion Date (mm/dd/yyyy)

_____

Print Name

_____ _____

Legal Signature Date (mm/dd/yyyy)

_____

Print Name of MD or Minnesota Licensed APRN

_____ _____

Legal Signature of MD or Minnesota Licensed APRN Date (mm/dd/yyyy)

☐ Physician License Number _____ State in which Physician is Licensed _____

☐ Minnesota APRN License Number _____

Return completed form to Minnesota Board of Nursing