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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 • Use black ink • Provide all information • Incomplete forms will be returned • Do not use initials or abbreviations

APPLICANT INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME
				<input type="checkbox"/> No middle name
STREET ADDRESS				
CITY		STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY
MINNESOTA LICENSE NUMBER			BIRTH DATE (mm/dd/yyyy)	
<input type="checkbox"/> APRN _____ <input type="checkbox"/> RN _____				
E-MAIL ADDRESS				
LAST DATE OF ADVANCED PRACTICE REGISTERED NURSE PRACTICE (mm/dd/yyyy)			TYPE OF PRACTICE	
			<input type="checkbox"/> EMPLOYMENT AS APRN	
			<input type="checkbox"/> VOLUNTEER AS APRN	
LEGAL SIGNATURE OF APPLICANT			DATE (mm/dd/yyyy)	

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

ADVANCED PRACTICE REGISTERED NURSE PRACTICE

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. If the APRN is currently employed, this date must be filled in. Please do not write "Current".

This person:

was employed as an APRN in the role of CNM CNP CNS CRNA and population of _____

Last date of practice (mm/dd/yyyy) _____ State in which practice occurred: _____

volunteered as an APRN in the role of CNM CNP CNS CRNA and population of _____

Last date of practice (mm/dd/yyyy) _____ State in which practice occurred: _____

is employed as an APRN in the role of CNM CNP CNS CRNA and population of _____

Last date of practice (mm/dd/yyyy) _____ State in which practice occurred: _____

NAME OF INSTITUTION, AGENCY, OR CONTRACTOR		FEDERAL FACILITY/AGENCY <input type="checkbox"/> Yes <input type="checkbox"/> No
STREET ADDRESS		CITY, STATE, ZIP CODE
SIGNATURE	TITLE	