MINNESOTA
BOARD OF NURSING

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Website: www.nursingboard.state.mn.us

# CONFIRMATION OF NURSING EMPLOYMENT FOR LICENSURE BY ENDORSEMENT

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 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 forms will be returned • Do not use initials or abbreviations**

| **APPLICANT INFORMATION** | | | | |
|---|---|---|---|---|
| LAST NAME | FIRST NAME | | MIDDLE NAME<br>☐ No middle name | |
| DATE OF LAST NURSING PRACTICE (mm/dd/yyyy) | TYPE OF PRACTICE<br>☐ Employed in nursing<br>☐ Volunteer nursing | | BIRTH DATE (mm/dd/yyyy) | |
| STREET ADDRESS ☐ Home ☐ Business | CITY | STATE PROVINCE | ZIP/POSTAL CODE | COUNTRY |
| LEGAL SIGNATURE OF APPLICANT | | | DATE (mm/dd/yyyy) | |

**SEND THIS FORM TO AN EMPLOYER FOR WHOM YOU HAVE WORKED AS A NURSE.**

- 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.

**NURSING PRACTICE**
To be completed by employer

**NOTE:** Verify this person's practice as nursing practice only if the person was employed or volunteered as a licensed registered nurse or licensed practical nurse or if the position required a license as a nurse.

This person: ☐ was employed as a nurse — last date of practice as a nurse (mm/dd/yyyy): _____

☐ volunteered as a nurse — last date of practice as a nurse (mm/dd/yyyy): _____

☐ is currently employed as a nurse — last date of practice as a nurse (mm/dd/yyyy): _____
If the nurse is currently employed, this date must be filled in. Please do not write "Current."

This person practiced as a: ☐ Registered Nurse ☐ Licensed Practical/Vocational Nurse

**State** in which practice occurred: _____

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

| SIGNATURE | TITLE | DATE (mm/dd/yyyy) |
|---|---|---|
| | | |