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CONFIRMATION OF NURSING EMPLOYMENT FOR REREGISTRATION

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 reregistration of your 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)	GENDER
<input type="checkbox"/> APRN _____ <input type="checkbox"/> RN _____ <input type="checkbox"/> LPN _____			<input type="checkbox"/> Male <input type="checkbox"/> Female
E-MAIL ADDRESS			
LAST DATE OF NURSING PRACTICE (mm/dd/yyyy)		TYPE OF PRACTICE	
		<input type="checkbox"/> EMPLOYMENT IN NURSING	
		<input type="checkbox"/> VOLUNTEER NURSING	
LEGAL SIGNATURE OF APPLICANT			DATE (mm/dd/yyyy)

- **SEND THIS FORM TO AN EMPLOYER FOR WHOM YOU HAVE WORKED AS A NURSE.** If you did not have an employer, a patient, volunteer supervisor, patient's family or physician, or a peer may verify nursing practice. This form must verify your most recent date of nursing practice.

NURSING PRACTICE	
NOTE: Verify this person's practice as nursing practice only if the person was employed or volunteered as an advanced practice, registered nurse, or licensed practical nurse or if the position required a license as a nurse.	
This person:	<input type="checkbox"/> was employed as a nurse last date of practice as a nurse (mm/dd/yyyy): _____
	<input type="checkbox"/> volunteered as a nurse last date of practice as a nurse (mm/dd/yyyy): _____
	<input type="checkbox"/> 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:	<input type="checkbox"/> APRN <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical/Vocational Nurse
State in which practice occurred: _____	
NAME OF INSTITUTION OR AGENCY	FEDERAL FACILITY/AGENCY <input type="checkbox"/> Yes <input type="checkbox"/> No
STREET ADDRESS	CITY, STATE, ZIP CODE
SIGNATURE	TITLE