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 NURSING EMPLOYMENT

☐ **Reregistration**
☐ **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, 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 • Provide all information • Incomplete forms will be returned • Do not use initials or abbreviations

APPLICANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
DATE OF LAST NURSING PRACTICE (mm/dd/yyyy) ☐ I have not worked as a nurse.	TYPE OF PRACTICE ☐ Employed in nursing ☐ Volunteer nursing	BIRTH DATE (mm/dd/yyyy)

STREET ADDRESS ☐ Home ☐ Business	CITY	STATE PROVINCE	ZIP/POSTAL CODE	COUNTRY

LEGAL SIGNATURE OF APPLICANT (Handwritten or electronic signature with time and date stamp. Typed signatures not accepted.)	DATE (mm/dd/yyyy)

SEND THIS FORM TO AN EMPLOYER FOR WHOM YOU MOST RECENTLY 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

VERIFY THIS PERSON'S PRACTICE IF EMPLOYED OR VOLUNTEERED IN A POSITION THAT REQUIRED A NURSE LICENSE.

Practiced as a: ☐ Licensed Practical/Vocational Nurse ☐ Registered Nurse

APRN in the role of: ☐ CNM ☐ CNP ☐ CNS ☐ CRNA

Last date of practice as a nurse (mm/dd/yyyy) _____ Do not write "current."

State in which practice occurred: _____

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

LEGAL SIGNATURE (Handwritten or electronic signature with time and date stamp. Typed signatures not accepted.)	TITLE	DATE (mm/dd/yyyy)