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 (800) 627-3529 – TTY
 Email: nursing.board@state.mn.us
 Website: www.nursingboard.state.mn.us

DOCUMENT REPLACEMENT REQUEST

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to update your record; issue replacement documents when appropriate; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements. Minnesota Statute Sec. 270C.72 requires licensees to provide their Social Security number and Minnesota business identification number on all license applications. All data submitted on the application, except social security number, is public. 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 the request. 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 requests will be returned • Do not use initials or abbreviations

| APPLICANT INFORMATION | | | |
|--|--------------------|--|--|
| LAST NAME | FIRST NAME | MIDDLE NAME | |
| | | <input type="checkbox"/> No middle name | |
| MAIDEN NAME | OTHER LAST NAME(S) | PHONE NUMBER <input type="checkbox"/> Home <input type="checkbox"/> Business () | |
| STREET ADDRESS | | | |
| CITY | STATE/PROVINCE | ZIP/POSTAL CODE | COUNTRY |
| E-MAIL ADDRESS | | BIRTH DATE (mm/dd/yyyy) | |
| UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72 | | <input type="checkbox"/> 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 LICENSE NUMBER <input type="checkbox"/> RN _____ <input type="checkbox"/> LPN _____ |

| REASON FOR REPLACEMENT | |
|--------------------------|--|
| <input type="checkbox"/> | Document Lost |
| <input type="checkbox"/> | Document stolen |
| <input type="checkbox"/> | Document damaged or destroyed |
| <input type="checkbox"/> | Name change. <ul style="list-style-type: none"> • Enclose a copy of legal proof of name change, such as a marriage certificate or court order. • Enclose the public health nurse certificate. |
| <input type="checkbox"/> | Other, explain: |

| DOCUMENT REQUESTED | |
|--------------------------|---|
| <input type="checkbox"/> | License (Document issued at the time of first licensure). Include \$20.00 nonrefundable fee. |
| <input type="checkbox"/> | APRN License (Document issued at the time of first licensure). Include \$20.00 nonrefundable fee. |
| <input type="checkbox"/> | Public Health Nurse Registration Certificate. Include \$5.00 nonrefundable fee. |

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

Return the completed form and nonrefundable fee (if required) to Minnesota Board of Nursing