

RN and LPN Licensure by Endorsement Instructions

If you have been licensed as a RN or LPN in a state or territory of the United States by examination, you must obtain a Minnesota license through the process of licensure by endorsement. You must:

Submit a *Licensure by Endorsement Application* form and fees. The application fee is \$105.00 and the Criminal Background Check fee is \$33.25. The total due is \$138.25 in the form of a money order or cashier's check made payable to the Minnesota Board of Nursing. Fees are non-refundable. The application packet may be downloaded from the Minnesota Board of Nursing website.

- Submit at least one verification of licensure:
 - submit verification from the state, territory or province in which you were first licensed and
 - submit verification from the state, territory or province that issued the license you are currently using to practice nursing. If the state in which you were first licensed is the same as the state in which you are currently practicing, you will submit one verification. If the state in which you were first licensed is different than the state in which you are currently practicing, you will submit two verifications.
- Verifications of licensure are completed online at www.nursys.com if the state processes their verifications through Nursys.com or by paper if they do not process their verifications through Nursys.com. The list of Nursys verifying states is available in the Licensure by Endorsement packet. The paper verification form is also available in the Licensure by Endorsement packet.
- Submit a *Confirmation of Nursing Employment for Licensure by Endorsement* form.
- Watch for the Criminal Background Check program office to send you a fingerprint packet by email. Follow the instructions and submit your fingerprints as soon as possible.

Anticipate receiving a letter from the Board if you need to report continuing education or successfully complete a refresher course. Continuing education requirements vary according to the date of most recent licensure and nursing practice. If you have not engaged in acceptable nursing practice for more than 5 years, you must successfully complete a refresher course that meets board criteria.

Before you are licensed in Minnesota, you may practice nursing in Minnesota under a temporary permit. The permit is valid until board action on your application or for 60 days, whichever comes first. Request the permit on the application form and submit a copy of your current nursing license.

Total Due: \$138.25 in U.S. funds (\$105.00 application fee and \$33.25 criminal background check fee). **Total Due: \$138.25**
 No personal checks. All fees are nonrefundable.



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

LICENSED PRACTICAL NURSE LICENSURE BY ENDORSEMENT APPLICATION

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. Minnesota Statute Sec. 270C.72 requires applicants to provide their Social Security number and Minnesota business identification number on all license applications.

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, except social security number and responses to grounds for denial questions, 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
- Use black ink
- Provide all information
- Incomplete applications are 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)		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
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 BUSINESS IDENTIFICATION NUMBER Required by Minn. Stat. Sec. 270C.72	
GRADUATION DATE (mm/dd/yyyy)				NAME OF SCHOOL OF NURSING (Program which qualified you to write the practical/vocational nurse licensure examination)				
CITY/STATE/COUNTRY OF SCHOOL OF NURSING						TYPE OF PROGRAM <input type="checkbox"/> RN <input type="checkbox"/> LPN		
BUSINESS ADDRESS: Minn. Stat. Sec. 214.073 requires licensees to provide their primary business address (if employed as a nurse) at the time of initial application and all renewals. Your license will not be issued unless you provide it or check the box below certifying that you are not currently in the workforce related to your practice.								
BUSINESS NAME (if employed as a nurse)								
STREET ADDRESS								
CITY				STATE/PROVINCE		ZIP/POSTAL CODE		
<input type="checkbox"/> I certify that I am not currently in the workforce related to my practice and I don't have a business address related to my practice.								

- Have you ever held a Minnesota LPN license? Yes No **If yes, do not complete this application. Contact the Board office.**
- Have you ever held a Minnesota RN license? Yes No If yes, Minnesota License Number: _____

LICENSURE INFORMATION

1. STATE IN WHICH LICENSED BY EXAMINATION	ORIGINAL LICENSE NUMBER	DATE ISSUED (mm/dd/yyyy)
2. NAME OF STATE/CANADIAN PROVINCE OF ORIGINAL LICENSURE IF DIFFERENT FROM #1	ORIGINAL LICENSE NUMBER	DATE ISSUED (mm/dd/yyyy)
3. STATE IN WHICH MOST RECENTLY EMPLOYED AS A LICENSED NURSE	ORIGINAL LICENSE NUMBER	DATE ISSUED (mm/dd/yyyy)

GROUND FOR DENIAL

Provide a written explanation for every YES response.

1.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever violated a state or federal law or rule relating to the practice of nursing in any state, territory or county?
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever violated a state or federal rule relating to narcotics or controlled substances or other similar regulations?
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been convicted, entered a plea of guilty, nolo contendere, or no contest, for any felony, gross misdemeanor or misdemeanor offense? NOTE: The fact that a conviction has been pardoned, dismissed, stayed, or deferred, or that your civil rights have been restored, does not mean that you answer "NO"; you should answer "YES."
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No	In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent?
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been fired from a nursing-related job in the last five years due to conduct that may be grounds for disciplinary action under the Nurse Practice Act?
6.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you under investigation or are you the subject of any pending or past disciplinary action or have you ever been refused a nursing license or any other occupational license in any state, territory or country?
7.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any physical or mental disability or illness that may impair your ability to practice nursing with reasonable skill and safety? Provide a statement explaining management and treatment. NOTE: If you are currently participating in the Health Professionals Services Program (HPSP) for this illness, you may answer "NO" to this question
8.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever received notification from the Minnesota Department of Human Services or the United States Department of Health and Human Services, Office of the Inspector General that you have been disqualified from providing direct care or excluded from participation in Medicare or Medicaid?

Check all of the following that apply to you within the past two years.

employed in nursing engaged in volunteer nursing after licensure, completed a degree program with a major in nursing

NURSING PRACTICE (Employment or Volunteer Nursing)

Complete this section no matter how long ago you practiced as a licensed practical/vocational nurse. The information will be used to determine if you must report continuing education, and if so, how many hours.

NAME OF INSTITUTION AT WHICH YOU PRACTICED NURSING	CITY, STATE/PROVINCE OR COUNTRY OF INSTITUTION AT WHICH YOU PRACTICED NURSING
LAST DATE OF NURSING PRACTICE (Month/Day/Year)	FEDERAL FACILITY <input type="checkbox"/> Yes <input type="checkbox"/> No

PERMIT REQUEST

A temporary permit allows you to practice nursing in Minnesota for 60 days.

I request a permit to practice nursing. Yes No

Office Use Only

Evidence satisfactory? Yes No Eligible for permit? Yes No

A criminal background check is required for licensure. The fee for this service is \$32.00 which is paid in addition to the \$105.00 application fee. The Criminal Background Check Program office will send a fingerprint packet and instructions to you by email.

I affirm that the statements and documents provided by me during the application process are true and correct.

Legal Signature of Applicant _____ **Date** _____



CONFIRMATION OF NURSING EMPLOYMENT FOR LICENSURE BY ENDORSEMENT

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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
DATE OF LAST NURSING PRACTICE (mm/dd/yyyy) TYPE OF PRACTICE BIRTH DATE (mm/dd/yyyy)
STREET ADDRESS 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)



Licensure by Endorsement Verification of Licensure Instructions

Submit verification from the state, territory or province in which you were first licensed and submit verification from the state, territory or province that issued the license you are currently using to practice nursing. If the state in which you were first licensed is the same as the state in which you are currently practicing, submit one verification. If the state in which you were first licensed is different than the state in which you are currently practicing, submit two verifications.

Go to www.nursys.com to process verifications of licensure for those states that process their verifications through Nursys.com. The list of Nursys verifying states is:

Alaska (AK)	Nebraska (NE)
American Samoa (AS)	Nevada (NV)
Arizona (AZ)	New Hampshire (NH)
Arkansas (AR)	New Jersey (NJ)
Colorado (CO)	New Mexico (NM)
Connecticut (CT)	New York (NY)
Delaware (DE)	North Carolina (NC)
District of Columbia (DC)	North Dakota (ND)
Florida (FL)	Northern Mariana Islands (MP)
Georgia (GA)	Ohio (OH)
Guam (GU)	Oklahoma (OK)
Idaho (ID)	Oregon (OR)
Illinois (IL)	Rhode Island (RI)
Indiana (IN)	South Carolina (SC)
Iowa (IA)	South Dakota (SD)
Kansas (KS)	Tennessee (TN)
Kentucky (KY)	Texas (TX)
Louisiana-RN (LA)	Utah (UT)
Maine (ME)	Vermont (VT)
Maryland (MD)	Virgin Islands (VI)
Massachusetts (MA)	Virginia (VA)
Michigan (MI)	Washington (WA)
Minnesota (MN)	West Virginia-PN(WV)
Mississippi (MS)	West Virginia-RN(WV)
Missouri (MO)	Wisconsin (WI)
Montana (MT)	Wyoming (WY)

Submit a paper *Verification of Licensure* form if you were first licensed or most recently licensed and practicing nursing in a state or territory of the United States not listed above or licensed in a Canadian province. The *Verification of Licensure* form is available in the Licensure by Endorsement packet on the Board's website.



VERIFICATION OF LICENSURE

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INSTRUCTIONS FOR VERIFICATION OF LICENSURE

- Complete APPLICANT INFORMATION.
Submit verification from the state in which you were first licensed. If that state processes their verifications through Nursys, you must verify licensure through www.nursys.com.
Submit verification from the state in which you are currently practicing nursing.

Type or print clearly Use black ink Provide all information Incomplete applications will be returned Do not use initials or abbreviation

Form with sections: APPLICANT INFORMATION, LAST NAME, FIRST NAME, MIDDLE NAME, MAIDEN NAME, OTHER LAST NAME(S), STREET ADDRESS, CITY, STATE/PROVINCE, ZIP/POSTAL CODE, COUNTRY, UNITED STATES SOCIAL SECURITY NUMBER, BIRTH DATE, ORIGINAL LICENSE NUMBER, ISSUE DATE, NAME OF NURSING SCHOOL, CITY/STATE/PROVINCE OF NURSING SCHOOL, LEGAL SIGNATURE OF APPLICANT, DATE.

↓ **THIS SECTION IS FOR LICENSING AGENCY USE ONLY** ↓

LICENSURE INFORMATION

LICENSE NUMBER OF NURSE REQUESTING VERIFICATION <input type="checkbox"/> RN <input type="checkbox"/> LPN		DATE ISSUED (mm/dd/yyyy):	
CURRENT LICENSURE STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> LAPSED <input type="checkbox"/> INACTIVE	EXPIRATION DATE (mm/dd/yyyy):	LICENSED BY <input type="checkbox"/> EXAMINATION <input type="checkbox"/> ENDORSEMENT	
Has this license ever been encumbered in any way? (Revoked, suspended, surrendered, restricted, limited, placed on probation, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach explanation and copy of the public documents.			
NAME OF NURSING EDUCATION PROGRAM COMPLETED		APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO	
CITY/ STATE/PROVINCE OF NURSING PROGRAM		GRADUATION DATE (mm/dd/yyyy):	

	STATE BOARD TEST POOL EXAMINATION					NCLEX®		
	Registered Nurse					LPN	RN	LPN
	Medical Nursing	Psychiatric Nursing	Obstetrical Nursing	Surgical Nursing	Nursing of Children			
Examination Results								
Series/Form Number								
Examination Date								

I certify that the above information accurately represents the information on file with the Board for the above named nurse.

Signature

OFFICIAL SEAL

Title

State/Province

Date (mm/dd/yyyy)

Return the completed form to Minnesota Board of Nursing