



## Minnesota RN and LPN Licensure by Endorsement Instructions

If you have been licensed by examination in the U.S. as a R.N. or L.P.N. and wish to practice nursing in Minnesota, you must obtain a Minnesota license through the process of licensure by endorsement. On the *Licensure by Endorsement Application*, you may request a temporary permit to practice in Minnesota while your application is under review. If you meet the requirements for a temporary permit, the Board will issue a permit which is valid until the Board grants you a license or for 60 days, whichever comes first. The permit cannot be extended or renewed. Don't delay submitting requirements; delays may result in the expiration of your permit or the loss of authorization to practice in Minnesota while your application is processed.

1. **Review Forms and Process:** Review the application for licensure on the Board of Nursing website at: <https://mn.gov/boards/nursing>. An overview of the licensure by endorsement process can be found below and on the Board's website at <https://mn.gov/boards/nursing/licensure/apply-for-a-license/lic-by-end-process.jsp>. If you are unable to determine which form(s) best fit your situation, please contact the Board for assistance.
2. Register to access the site by setting up an online user account with a username and password. This will allow you to apply online and check the status of your application online.
3. **Complete the following forms:**
  - a. **Licensure by Endorsement Application form.** Apply online or print the application from the Board's website. If applying by paper, complete the paper application form, sign, and submit the application with the fee to the Board by mail. You must submit either a *Registered Nurse Licensure by Endorsement Application* form or a *Practical Nurse Licensure by Endorsement Application* form.
  - b. **Verification of Licensure form.** You must submit verification from the state, territory or province in which you were first licensed. You must also submit verification from the state, territory or province that issued the license you are currently using to practice nursing if that is different than your state of initial licensure. (*i.e.*, You will need two forms of verification requests if the state where you were first licensed is different than the state where you have most recently practiced. If the state where you were first licensed is the same as the state where you have most recently practiced, you will need only one verification request or form.) Most states process their verification of licensure requests through Nursys. You can check for information regarding participating states and complete the verification request(s) online at [www.Nursys.com](http://www.Nursys.com). If a state processes their verification requests by paper, print the *Verification of Licensure* form from the Board's website and submit it to that state.
  - c. **Confirmation of Nursing Employment form.** If you have ever worked as a nurse, you must have your most recent employer complete and submit a *Confirmation of Nursing Employment for Licensure by Endorsement* form. Print the form from the Board's website and submit to your current nursing employer. If you are not currently employed, submit the form to your most recent nursing employer. Upon completion, you must return the form to the Board.
  - d. **Criminal Background Check.** When you submit your application for endorsement, the Criminal Background check office will send you a fingerprint packet by email. Follow the instructions from the Criminal Background check office that you receive with the packet. Criminal Background Check contact: email [Criminal.Background.Check@state.mn.us](mailto:Criminal.Background.Check@state.mn.us) or call 651-201-2822 if you have questions.
  - e. **Continuing Education form.** You may need to report continuing education or successfully complete a refresher course depending on how long it has been since you last practiced nursing. The Board will contact you if you are required to report continuing education when your *Confirmation of Nursing Employment* form has been processed.
4. **Confirmation of Application Submission:** You are responsible for submitting all necessary forms and fees to complete your application. The Board encourages you to confirm successful submission of your application forms and to check the status of processing your application by visiting your online services account.



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

**REGISTERED 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 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)			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 registered nurse licensure examination)								
CITY/STATE/COUNTRY OF SCHOOL OF NURSING						DEGREE TYPE			<input type="checkbox"/> Diploma		
						<input type="checkbox"/> Associate Degree			<input type="checkbox"/> Masters		
						<input type="checkbox"/> Baccalaureate			<input type="checkbox"/> Doctorate		
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 RN license?  Yes  No **If yes, do not complete this application. Contact the Board office.**
- Have you ever held a Minnesota LPN 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 country?
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 currently impairs your ability to practice nursing with reasonable skill and safety? <b>Provide a statement explaining management and treatment.</b> 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?

I am an Advanced Practice Registered Nurse (**attach a copy of your current certificate**), certified as a:

Clinical Nurse Specialist     Nurse Anesthetist     Nurse-Midwife     Nurse Practitioner

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 registered nurse. This 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 (mm/dd/yyyy)	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 \$33.25 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

- Reregistration
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, 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
DATE OF LAST NURSING PRACTICE, TYPE OF PRACTICE, BIRTH DATE
STREET ADDRESS, CITY, STATE PROVINCE, ZIP/POSTAL CODE, COUNTRY
LEGAL SIGNATURE OF APPLICANT, DATE

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
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, volunteered as a nurse, is currently employed as a nurse
This person practiced as a: APRN, Registered Nurse, Licensed Practical/Vocational Nurse
State in which practice occurred:
NAME OF INSTITUTION OR AGENCY, FEDERAL FACILITY/AGENCY
STREET ADDRESS, CITY, STATE, ZIP CODE
LEGAL SIGNATURE, TITLE, DATE



## 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](http://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:

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

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

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, 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.

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			
<b>Examination Results</b>								
<b>Series/Form Number</b>								
<b>Examination Date</b>								

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