MINNESOTA
BOARD OF NURSING

2829 University Avenue SE #200, Minneapolis, MN 55414-3253
Voice: 612-317-3000 | Fax: 612-617-2190 |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

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.

Revised 12/14/18

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.

MINNESOTA BOARD OF NURSING

2829 University Avenue SE #200, Minneapolis, MN 55414-3253
Voice: 612-317-3000 | Fax: 612-617-2190 |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 ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
E-MAIL ADDRESS	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female

UNITED STATES SOCIAL SECURITY NUMBER
Required by Minn. Stat. Sec. 270C.72

			-			-				

☐ 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 ☐ Diploma ☐ Associate Degree ☐ Masters ☐ Baccalaureate ☐ 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

☐ 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** _____

-over-

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)

GROUNDS FOR DENIAL

Provide a written explanation for every *YES* response.

1.	☐ Yes ☐ 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.	☐ Yes ☐ No	Have you ever violated a state or federal rule relating to narcotics or controlled substances or other similar regulations?
3.	☐ Yes ☐ 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.	☐ Yes ☐ No	In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent?
5.	☐ Yes ☐ 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.	☐ Yes ☐ 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.	☐ Yes ☐ 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.	☐ Yes ☐ 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 ☐Yes ☐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** _____

MINNESOTA BOARD OF NURSING

2829 University Avenue SE #200, Minneapolis, MN 55414-3253
Voice: 612-317-3000 | Fax: 612-617-2190 |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 FOR LICENSURE BY 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 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 ☐ No middle name	
DATE OF LAST NURSING PRACTICE (mm/dd/yyyy)	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			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)

MINNESOTA
BOARD OF NURSING

2829 University Avenue SE #200, Minneapolis, MN 55414-3253
Voice: 612-317-3000 | Fax: 612-617-2190 |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

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

Revised: 8/9/18

MINNESOTA
BOARD OF NURSING

2829 University Avenue SE #200, Minneapolis, MN 55414-3253
Voice: 612-317-3000 | Fax: 612-617-2190 |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

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. If they do not process their verifications through Nursys, send this form and any required fee to that state for verification. In addition, if you were first license in Canada by examination, send this form to the Canadian province in which you were licensed.
- Submit verification from the state in which you are currently practicing nursing. If this is the same state in which you were licensed by examination, submit only one verification. If the state in which you are practicing nursing processes their verifications through Nursys, you must verify licensure through www.nursys.com. If they do not process their verifications through Nursys, send this form and any required fee to that state for verification.

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

APPLICANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY

UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72	☐ 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	BIRTH DATE (mm/dd/yyyy)
___ ___ ___ - ___ ___ - ___ ___ ___ ___		

ORIGINAL LICENSE NUMBER	ISSUE DATE (mm/dd/yyyy)
NAME OF NURSING SCHOOL (No initials)	CITY/STATE/PROVINCE OF NURSING SCHOOL

I hereby authorize the _____ licensing authority to furnish the Minnesota
State/Province
Board of Nursing the information requested on the reverse side of this form.

LEGAL SIGNATURE OF APPLICANT	DATE (mm/dd/yyyy):

Reverse side must be completed by Licensing Agency.

⬇ THIS SECTION IS FOR LICENSING AGENCY USE ONLY ⬇

LICENSURE INFORMATION

LICENSE NUMBER OF NURSE REQUESTING VERIFICATION ☐ RN ☐ LPN	DATE ISSUED (mm/dd/yyyy):

CURRENT LICENSURE STATUS ☐ ACTIVE ☐ LAPSED ☐ INACTIVE	EXPIRATION DATE (mm/dd/yyyy):	LICENSED BY ☐ EXAMINATION ☐ ENDORSEMENT

Has this license ever been encumbered in any way? (Revoked, suspended, surrendered, restricted, limited, placed on probation, etc.)

☐ Yes ☐ No If yes, attach explanation and copy of the public documents.

NAME OF NURSING EDUCATION PROGRAM COMPLETED	APPROVED ☐ YES ☐ 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