



2829 University Avenue SE #200
Minneapolis, MN 55414-3253
(612) 317-3000 – Voice (612) 617-2190 – Fax
Toll Free (888) 234-2690 (MN, IA, ND, SD, WI)
(800) 627-3529 – TTY
Email: nursing.board@state.mn.us
Website: www.nursingboard.state.mn.us

Licensure by Endorsement Instructions

If you have been licensed 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 fee. You can print the form from the Board's website or access the online licensure by endorsement application by clicking on the "Licensure" tab, click on the "Apply for License" link, and click on the "Apply by Endorsement" link.
- 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.

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.

Date: 7/3/2013

Revised: 08/19/2015



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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"/> Baccalaureate <input type="checkbox"/> Masters <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 been licensed as a registered nurse in Minnesota? 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	ORIGINAL DATE ISSUED (mm/dd/yyyy)
2. NAME OF STATE/CANADIAN PROVINCE OF ORIGINAL LICENSURE IF DIFFERENT FROM #1	ORIGINAL LICENSE NUMBER	ORIGINAL DATE ISSUED (mm/dd/yyyy)
3. STATE IN WHICH MOST RECENTLY EMPLOYED AS A LICENSED NURSE	ORIGINAL LICENSE NUMBER	ORIGINAL 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, expunged, 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?

I am an Advanced Practice Registered Nurse, certified as a Clinical Nurse Specialist Nurse Anesthetist
 Nurse-Midwife Nurse Practitioner
Attach a copy of your current certificate.

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

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

Legal Signature of Applicant

Return completed form and nonrefundable fee in U.S. funds to Minnesota Board of Nursing



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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.

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- 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	
				<input type="checkbox"/> No middle name	
DATE OF LAST NURSING PRACTICE (mm/dd/yyyy)		TYPE OF PRACTICE		BIRTH DATE (mm/dd/yyyy)	
		<input type="checkbox"/> Employed in nursing <input type="checkbox"/> Volunteer nursing			
STREET ADDRESS <input type="checkbox"/> Home <input type="checkbox"/> 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 you did not have an employer, a patient, volunteer supervisor, patient's family or physician, or a peer may verify nursing practice. This form must verify your most recent date of nursing practice.

NURSING PRACTICE	
↓Applicant: Do not write below this line.↓	
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:	<input type="checkbox"/> was employed as a nurse last date of practice as a nurse (mm/dd/yyyy): _____ <input type="checkbox"/> volunteered as a nurse last date of practice as a nurse (mm/dd/yyyy): _____ <input type="checkbox"/> 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:	<input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical/Vocational Nurse
State in which practice occurred: _____	
NAME OF INSTITUTION OR AGENCY	FEDERAL FACILITY/AGENCY <input type="checkbox"/> Yes <input type="checkbox"/> No
STREET ADDRESS	CITY, STATE, ZIP CODE
SIGNATURE	DATE (mm/dd/yyyy) TITLE

Return completed form to Minnesota Board of Nursing



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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)	Oregon (OR)
Idaho (ID)	Rhode Island (RI)
Illinois (IL)	South Carolina (SC)
Indiana (IN)	South Dakota (SD)
Iowa (IA)	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)	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.

Revised: 8/2015



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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. 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.

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APPLICANT INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME	
				<input type="checkbox"/> 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			<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		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 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 <input type="checkbox"/> RN <input type="checkbox"/> LPN	DATE ISSUED (mm/dd/yyyy):
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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
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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 <input type="checkbox"/> YES <input type="checkbox"/> NO
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CITY/ STATE/PROVINCE OF NURSING PROGRAM	GRADUATION DATE (mm/dd/yyyy):
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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)