MINNESOTA BOARD OF NURSING

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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

POST-GRADUATE PRACTICE VERIFICATION FOR CNP AND CNS

The information and evidence you are asked to provide on this form is authorized by Minnesota Statutes. The data you supply will used to verify completion of 2,080 hours of post-graduate practice for Nurse Practitioners and Clinical Nurse Specialists.

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 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

Complete the applicant information and one of the following sections; initiation of practice, affidavit of post-graduate practice completion, or verification of completion of post-graduate practice.

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
EMAIL ADDRESS		
MINNESOTA LICENSE NUMBER ☐ RN _____	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female

INITIATION OF PRACTICE

This section must be completed by an individual who has not completed the 2,080 post-graduate practice hours and is or is not initially entering into practice at this time as a Certified Nurse Practitioner or Clinical Nurse Specialist. If you are initiating practice, provide information about the hospital or integrated clinical setting in which you are initiating practice below.

☐ I am not initiating APRN practice upon licensure at this time.

☐ I am initiating APRN practice upon licensure at location below.

NAME OF HOSPITAL OR INTEGRATED CLINICAL SETTING			
STREET ADDRESS			
CITY	STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY

-over-

Complete the Affidavit of Post-Graduate Practice Completion section or the Verification of Completion of Post-Graduate Practice section.

AFFIDAVIT OF POST-GRADUATE PRACTICE COMPLETION

This section must be completed by an APRN who was listed on the Minnesota APRN Registry as of July 1, 2014.

I affirm that I have completed 2,080 hours of post-graduate practice and was listed on the Minnesota APRN Registry as of July 1, 2014, which means that you held a Minnesota RN license and the Minnesota Board of Nursing had a current copy of your certification as an APRN.

The undersigned does hereby affirm that the statements contained in this application are true and correct.

_____

Print Name

_____ _____

Legal Signature Date (mm/dd/yyyy)

- OR -

VERIFICATION OF COMPLETION OF POST-GRADUATE PRACTICE

This section must be completed by a Certified Nurse Practitioner or Clinical Nurse Specialist who has completed 2,080 hours within the context of collaborative agreement within a hospital or integrated clinical setting where advanced practice registered nurses and physicians work together to provide patient care. Report the actual completion date.

☐ I have completed 2,080 hours of APRN practice within the context of a collaborative agreement within a hospital or integrated clinical setting

_____

Completion Date (mm/dd/yyyy)

_____

Print Name

_____ _____

Legal Signature Date (mm/dd/yyyy)

_____

Print Name of MD or Minnesota Licensed APRN

_____ _____

Legal Signature of MD or Minnesota Licensed APRN Date (mm/dd/yyyy)

☐ Physician License Number _____ State in which Physician is Licensed _____

☐ Minnesota APRN License Number _____

Return completed form to Minnesota Board of Nursing