Office Use Only
Report Period _____
Firm Number _____

MINNESOTA 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

PROFESSIONAL NURSING FIRM ANNUAL REPORT

The information and evidence you are asked to provide is authorized by Minnesota Statutes, Chapter 319B.11 Subdivision 4.

● Print or Type ● Use Black Ink

Name of Professional Firm (Specify complete name filed with the Minnesota Secretary of State)	
Street Address	
City, State, ZIP Code	Phone Number

1. Designate the **position or positions** within the firm that have governance authority. (Do not use individual's names.)

POSITION

2. Provide the name, address and Minnesota License number for each owner of an ownership interest and each person occupying a position with governance authority.

NAME	ADDRESS	OWNER	GOVERNANCE AUTHORITY	MINNESOTA LICENSE #
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	

3. Indicate the types of professional services furnished by the firm.

☐ Nursing ☐ Medicine ☐ Psychology
☐ Chiropractic ☐ Optometry ☐ Dentistry/Dental Hygiene

-over-

4. List all registered and practical nurse employees as of the date this report is sent to the Board of Nursing. Attach an extra page if necessary.

NAME	CATEGORY RN - LPN	MN LICENSE NUMBER	DATE REGISTRATION EXPIRES

5. Check the types of locations at which professional services are provided.

☐ Office/Clinic ☐ Hospital ☐ Nursing Home

☐ Client Residence ☐ School ☐ Other _ _____

6. Are unlicensed assistive personnel employed to render nursing care? ☐ Yes ☐ No If yes, are the assistants supervised by a registered nurse? ☐ Yes ☐ No If not supervised by a registered nurse, please explain:

__ _____

_____

7. Were the Articles of Incorporation, By-Laws, Certification of Authority or Statement of Qualifications amended during the reporting period shown on the front? ☐ Yes ☐ No If yes, attach an amended copy.

I certify that all employees, agents and independent contractors furnishing professional services within Minnesota on behalf of the professional firm are licensed and currently registered to furnish the professional service.

Subscribed and sworn to before me

This _____ day of _____, _____
Day Month Yea

State of _____ County of _____

_____
Signature-Notary Public

Commission Expiration Date:

Affix Notary Seal or Stamp

_____
Name of Registered Nurse who is an owner or employee of the firm and authorized to submit this report

_____
Title

_____
Signature

_____
Date

Annual Fee: $25.00 check payable to the *Minnesota Board of Nursing.*

Forward this report (notarized), attachments, if any, and fee by January 1st to:
Minnesota Board of Nursing
1210 Northland Drive #120
Mendota Heights, MN 55120

Office Use Only

Fee Amount:	Received By:	Date Received: