



Reregistration Instructions

If you have been licensed in Minnesota but have not renewed, reregistration is the process by which you reactive your license. Requirements vary depending on how long your registration has been expired and how long it has been since you last practiced nursing. You must:

- Submit a *Reregistration Application* form and fee. You can print the form from the Board’s website by clicking on the “RN & LPN Licensure” tab, click on the “License Renewal” link, click on the “Reregistration” link or access the online reregistration application by clicking on the Online Services link and logging into your licensee account.
- Submit a *Confirmation of Nursing Employment for Reregistration* form.

You may also have to complete and report continuing education. If you have not practiced nursing for five years or more, you are required to take a nurse refresher course.

When your complete application is received, the Board will inform you whether to report continuing education hours and whether you are required to take a nurse refresher course.



BOARD OF NURSING

All fees are nonrefundable

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

REREGISTRATION APPLICATION

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine eligibility for reregistration of your license; 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. All data submitted on the application, except social security number and responses to grounds for denial questions, is public. 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
If you have been licensed in Minnesota but have not renewed, reregistration is the process by which you reactivate your license. Requirements vary depending on how long your registration has been expired and how long it has been since you last practiced nursing. You must submit an application, fee, and confirmation of nursing employment form. You may also have to complete and report continuing education. If you have not practiced nursing for five years or more, you are required to take a nurse refresher course. When your complete application is received, the Board will inform you whether to report continuing education hours and whether you are required to take a nurse refresher course.

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
MAIDEN NAME OTHER LAST NAME(S) PHONE NUMBER
STREET ADDRESS CITY
STATE/PROVINCE ZIP/POSTAL CODE COUNTRY
E-MAIL ADDRESS BIRTH DATE GENDER
MINNESOTA LICENSE NUMBER
UNITED STATES SOCIAL SECURITY NUMBER MINNESOTA BUSINESS IDENTIFICATION NUMBER
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.

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 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?

NURSING PRACTICE

Have you ever practiced nursing? Yes No If yes, complete this section no matter how long ago you practiced nursing. This information will be used to determine if you must report continuing education, and if so, how many hours.

Nursing practice is employment or volunteer work which required a current nursing license. It is important you report only a position that **required** you to be a nurse. Your last date of practice might not be the last date of employment, for example you were on vacation or a leave of absence and did not practice nursing.

NAME OF INSTITUTION	STATE IN WHICH PRACTICE OCCURRED
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FEDERAL FACILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST DATE OF NURSING PRACTICE (mm/dd/yyyy)
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FEE CALCULATION

Have you practiced nursing in Minnesota after your registration expired? Yes No If yes, state number of months or part(s) of months during which you practiced without current registration _____. Use the penalty fee schedule below to determine the fee amount that you owe. **The penalty fee must be paid in the form of a certified check or money order and submitted at the time you submit your reregistration application.**

Penalty Fee Schedule for Practicing Without Current Registration

Month(s) Worked	Penalty Fee	Months Worked	Penalty Fee	Months Worked	Penalty Fee	Months Worked	Penalty Fee
1	\$170.00	7	\$680.00	13	\$1,190.00	19	\$1,700.00
2	\$255.00	8	\$765.00	14	\$1,275.00	20	\$1,785.00
3	\$340.00	9	\$850.00	15	\$1,360.00	21	\$1,870.00
4	\$425.00	10	\$935.00	16	\$1,445.00	22	\$1,955.00
5	\$510.00	11	\$1,020.00	17	\$1,530.00	23	\$2,040.00
6	\$595.00	12	\$1,105.00	18	\$1,615.00	24	\$2,125.00

FEE AMOUNT REQUIRED:

\$105.00 Reregistration Fee

\$ _____ Penalty Fee (money order/cashier's check only)

\$ _____ TOTAL ENCLOSED (All fees are nonrefundable)

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 FOR REREGISTRATION

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine eligibility for reregistration of your license; enable us to contact you when necessary; and identify you. All data submitted on the application is a 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
STREET ADDRESS
CITY STATE/PROVINCE ZIP/POSTAL CODE COUNTRY
MINNESOTA LICENSE NUMBER BIRTH DATE (mm/dd/yyyy) GENDER
E-MAIL ADDRESS
LAST DATE OF NURSING PRACTICE (mm/dd/yyyy) TYPE OF PRACTICE
LEGAL SIGNATURE OF APPLICANT DATE (mm/dd/yyyy)

SEND THIS FORM TO AN EMPLOYER OR CONTRACTOR 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 an advanced practice, 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: [] APRN [] 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)