



2829 University Avenue SE #200
Minneapolis, MN 55414-3252
(612) 617-2270 – 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

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 the application for licensure by endorsement and fee. This can be done online. On the Home page under Top Links, click on Licensure by Endorsement.
- Submit at least one “Verification of Licensure” form.
- Submit a “Confirmation of Nursing Employment” 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.

Before you are licensed in Minnesota, you may practice nursing in Minnesota under a temporary permit. Request the permit on the application form and submit a copy of your current nursing license.

Application fee **\$105.00 U.S.**
 No personal checks
 All fees are nonrefundable



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REGISTERED NURSE LICENSURE BY ENDORSEMENT APPLICATION

The information and evidence you are asked to provide is authorized by Minnesota Statutes and will be used to determine your qualifications for licensure. The data you supply become part of your permanent file. Until licensure is granted all application data, except name and designated address, are private data and will not be released to anyone other than the Board of Nursing staff and its agents. In the event of any legal proceedings between you and the Board, the information may be disclosed to appropriate judicial authorities or others in accordance with statutes, rules and professional standards. All data, except social security number, becomes public record when licensure is granted. Social security number and Minnesota business identification number will be used by the Minnesota Department of Revenue for tax clearance purposes and by the Board of Nursing as identifiers.

You are legally required to submit true and complete information. 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 are 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)		PREVIOUS MIDDLE NAME
STREET ADDRESS <input type="checkbox"/> Home <input type="checkbox"/> Business			CITY	
STATE /PROVINCE	ZIP/POSTAL CODE	COUNTRY		E-MAIL ADDRESS
BIRTH DATE (Month/Day/Year)	AGE	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NUMBER <input type="checkbox"/> US <input type="checkbox"/> Canadian <small>[Required by Minn. Stat. 270C.72 (2008)]</small>	PHONE NUMBER <input type="checkbox"/> Home <input type="checkbox"/> Business ()
GRADUATION DATE (Month/Day/Year)	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"/> Associate Degree <input type="checkbox"/> Masters <input type="checkbox"/> Baccalaureate <input type="checkbox"/> Doctorate	

GROUNDS FOR DENIAL

Provide a written explanation for every YES response.

1. Have you ever violated a state or federal law or rule relating to the practice of nursing in any state, territory or country?
 Yes No
2. Have you ever violated a state or federal law or rule relating to narcotics or controlled substances or other similar regulations?
 Yes No
3. 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."* Yes No
4. In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent?
 Yes No
5. 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? Yes No
6. 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? Yes No
7. Do you have any physical or mental disability or illness that may impair your ability to practice nursing with reasonable skill and safety? Yes No **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. 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? Yes No

(over)

- 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 (Month/Day/Year)
2. NAME OF STATE/CANADIAN PROVINCE OF ORIGINAL LICENSURE IF DIFFERENT FROM #1	ORIGINAL LICENSE NUMBER	ORIGINAL DATE ISSUED (Month/Day/Year)
3. STATE IN WHICH MOST RECENTLY EMPLOYED AS A LICENSED NURSE	ORIGINAL LICENSE NUMBER	ORIGINAL DATE ISSUED (Month/Day/Year)

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.

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 (Month/Day/Year)	FEDERAL FACILITY <input type="checkbox"/> Yes <input type="checkbox"/> No

PERMIT REQUEST

A temporary permit allows you to practice nursing in Minnesota prior to licensure.

I request a permit to practice nursing. **Submit a copy of your current nursing license.**

Office Use Only

Evidence satisfactory? Yes No Eligible for permit? Yes No

AFFIDAVIT SECTION

To be signed and sworn to in the presence of a notary public.

<p>Subscribed and sworn to before me</p> <p>this _____ day of _____ Year _____</p> <p>State/Province of _____</p> <p>County of _____</p> <p>_____ Signature of Notary Public</p> <p>Notary Commission Expires _____ Month/Day/Year</p> <p align="center">Affix Notary Seal or Stamp</p>	<p>I affirm that the statements and documents provided by me during the application process are true and correct.</p> <p>_____ Legal Signature of Applicant</p>
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CONFIRMATION OF NURSING EMPLOYMENT FOR LICENSURE BY ENDORSEMENT

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- Use black ink
- Provide all information
- Incomplete forms are returned
- Do not use initials or abbreviations

APPLICANT INFORMATION				
LAST NAME	FIRST NAME	MIDDLE <input type="checkbox"/> No Middle Name		
DATE OF LAST NURSING PRACTICE (Month/Day/Year)	TYPE OF PRACTICE <input type="checkbox"/> Employed in nursing <input type="checkbox"/> Volunteer nursing	SOCIAL SECURITY NUMBER <input type="checkbox"/> US or <input type="checkbox"/> Canadian	BIRTH DATE (Month/Day/Year)	
STREET ADDRESS <input type="checkbox"/> Home <input type="checkbox"/> Business	CITY	STATE PROVINCE	ZIP/POSTAL CODE	COUNTRY
LEGAL SIGNATURE OF APPLICANT			DATE (Month/Day/Year)	

- **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: ____/____/____ <small>Month Day Year</small>
<input type="checkbox"/> volunteered as a nurse	last date of practice as a nurse: ____/____/____ <small>Month Day Year</small>
<input type="checkbox"/> is currently employed as a nurse.	Last date practiced as a nurse: ____/____/____ 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 (Month/Day/Year) TITLE



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You must go to www.nursys.com to process an online verification request, if you were first licensed or most recently licensed and practicing nursing in:

Alaska (AK)	New Jersey (NJ)
Arizona (AZ)	New Mexico (NM)
Arkansas (AR)	North Carolina (NC)
Colorado (CO)	North Dakota (ND)
Delaware (DE)	Ohio (OH)
Florida (FL)	Oregon (OR)
Idaho (ID)	Rhode Island (RI)
Indiana (IN)	South Carolina (SC)
Iowa (IA)	South Dakota (SD)
Kentucky (KY)	Tennessee (TN)
Maine (ME)	Texas (TX)
Maryland (MD)	Utah (UT)
Massachusetts (MA)	Vermont (VA)
Minnesota (MN)	Virginia (VA)
Mississippi (MS)	Washington (WA)
Missouri (MO)	West Virginia-PN (WV)
Montana (MT)	Wisconsin (WI)
Nebraska (NE)	Wyoming (WY)
New Hampshire (NH)	

You must submit a “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. To print this form, go to the Minnesota Board of Nursing Home page. Select the “Application Forms.” Select and print “Licensure Verification” form. You may have to print two verification forms if more than one state, territory, or Canadian province are applicable.



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VERIFICATION OF LICENSURE

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INSTRUCTIONS FOR VERIFICATION OF LICENSURE

- Complete **APPLICANT INFORMATION**.
- Contact the licensing authority in the state/province in which you were licensed to determine if there is a fee for verification of licensure.
- Send this form and fee to the state in which you were licensed by examination. In addition, if you were first licensed in Canada by examination, send this form to the Canadian province in which you were licensed.
- Send this form to the state/province that issued the license you are currently using to practice nursing. If this is the same state in which you were licensed by examination, send only one form to the state.

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APPLICANT INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME <input type="checkbox"/> No middle name	
MAIDEN NAME		OTHER LAST NAME(S)	
CURRENT ADDRESS		CITY, STATE/PROVINCE, ZIP/POSTAL CODE	
ORIGINAL LICENSE NUMBER	ISSUE DATE (Month/Day/Year)	SOCIAL SECURITY NUMBER <small>[Required by Minn. Stat. 270C.72 (2005)]</small>	BIRTH DATE (Month/Day/Year)
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. State/Province			
LEGAL SIGNATURE OF APPLICANT			DATE (Month/Day/Year)

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 (Month/Day/Year)
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CURRENT LICENSURE STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> LAPSED <input type="checkbox"/> INACTIVE	EXPIRATION DATE (Month/Day/Year)	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 (Month/Day/Year)
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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.

OFFICIAL SEAL

Signature

Title

State/Province

Date