



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

## CONFIRMATION OF NURSING EMPLOYMENT FOR LICENSURE BY ENDORSEMENT

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 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.↓	
<b>NOTE:</b> 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.	If the nurse is currently employed, this date
Last date practiced as a nurse: ____/____/____ <small>Month Day Year</small>	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