The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
Board of Registration in Nursing
www.mass.gov/dph/boards/rn

VERIFICATION OF NURSE LICENSURE

APPLICANT: COMPLETE THIS SECTION ONLY

I, _____, RN ☐ LPN/LVN ☐ License Number _____, am applying to the Massachusetts Board of Nursing for licensure by reciprocity. I hereby authorize you to furnish to the Massachusetts Board of Nursing the information requested below.

This is the original state of issue? Yes ☐ No ☐

_____

(Date) (Signature) (Maiden Name)

APPLICANT: DO NOT WRITE BELOW THIS LINE

Applicant Name as Appearing on Original License _____

Applicant Name as Appearing on Current License _____

NURSING EDUCATION

PROGRAM NAME AND LOCATION: _____

_____ **Board Approved: Yes ☐ No ☐**

Language of Nursing: Classroom Instruction _____ **Course Textbooks** _____ **Clinical Practice** _____

Program: ☐ **Practical Nurse/Vocational Nurse** ☐ **Registered Nurse** ☐ **Withdrawn from RN program**

Type: ☐ **Certificate** ☐ **Diploma** **Degree:** ☐ **Associate** ☐ **Baccalaureate** ☐ **Entry Level Masters**

Month/Year Graduated (or withdrawn, if applicable) _____ **Length of Program** _____

Applicant Registration Number _____ **Date of Original Issue** _____

Current Licensure Status: _____ **Expiration Date** _____

Method of Licensure (Check One): Examination ☐ **Waiver** ☐ **Reciprocity** ☐

Type of Exam: NCLEX ☐ **SBTPE** ☐ **Exam Date** _____

Has License Ever Been Disciplined? Yes ☐ No ☐ *(If "Yes", Provide A Certified Copy of All Related Documents.)*

Is Applicant Currently Under Investigation? Yes ☐ No ☐ *(If "Yes" Please Explain.)*

I certify the above to be a true report for the above-named Nurse according to the records in this office.

Authorized Person **Signature:** _____ **Date:** _____

Print Name: _____ **Title:** _____ **Jurisdiction:** _____

Affix Board Seal

Mail to:

Professional Credential Services
ATTN: MA Nurse Coordinator
P.O. Box 198788
Nashville, TN 37219

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VERIFICATION OF ADVANCED PRACTICE REGISTERED NURSE AUTHORIZATION

***APPLICANT: COMPLETE THIS SECTION ONLY**

I, _____, APRN License Number _____, am applying to the Massachusetts Board of Nursing for Advanced Practice authorization by reciprocity. I hereby authorize you to furnish to the Massachusetts Board of Nursing the information requested below.

_____

(Date) (Signature) (Maiden Name)

APPLICANT: DO NOT WRITE BELOW THIS LINE

Applicant Name as Appearing on Original License _____

Applicant Name as Appearing on Current License _____

Advance Practice Program _____ **Year Graduated** _____

Location _____ **Board Approved: Yes** ☐ **No** ☐

Type of Program _____ **Length of Program** _____

APRN Registration Number _____ **Date of Original Issue** _____

Current Licensure Status: _____ **Expiration Date** _____

Method of Authorization: (Check One) Original ☐ **Waiver** ☐ **Reciprocity** ☐

National Certification by: _____ **Exam Date:** _____

Has License Ever Been Disciplined? Yes ☐ **No** ☐ *(If "Yes", Provide A Certified Copy of All Related Documents.)*

Is Applicant Currently Under Investigation? Yes ☐ **No** ☐ *(If "Yes" Please Explain.)*

I certify the above to be a true report for the above-named Nurse according to the records in this office.

Authorized Person **Signature:** _____ **Date:** _____

Print Name: _____ **Title:** _____ **Jurisdiction:** _____

Affix Board Seal

Mail to:

Professional Credential Services
ATTN: MA Nurse Coordinator
P.O. Box 198788
Nashville, TN 37219