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 ADVANCED PRACTICE REGISTERED NURSE AUTHORIZATION

This verification will expire 6 months from the date of receipt by PCS.

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