The Commonwealth of Massachusetts

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

CERTIFICATION OF GRADUATION FROM AN OUT OF STATE NURSING EDUCATION PROGRAM

To be completed by Program Administrator, (the Registered Nurse designated the administrative authority and responsibility for the nursing education program), for all graduates of nursing education programs located outside of Massachusetts in the U.S. or its territories that are applying for initial licensure by examination in Massachusetts.

- A Board-issued NCLEX Eligibility Certificate must be attached to the *Application for Initial Nurse Licensure by Examination* by graduates of non-U.S. nursing education programs.
- A Board-issued NCLEX-PN Eligibility Certificate must be attached to the *Application for Initial Nurse Licensure by Examination* for former RN nursing education program students withdrawn in good standing who meet PN curriculum requirements.

I hereby certify that _____
(**Applicant's Name/Year of Birth**) **First** **Middle** **Last** **Year of Birth**

graduated from _____
(Nursing Education Program)

located _____
(City/Town) **(Zip/Postal Code)**

Date of Graduation* _____ **Date Degree or Certificate conferred/awarded** _____
(*244 CMR 8.01; Graduation means the date the applicant graduated from a nursing education program as defined in the policy of the applicant's nursing education program).

Program Type ☐ PRACTICAL/VOCATIONAL NURSE ☐RN DIPLOMA ☐RN ASSOCIATE DEGREE
Check one * ☐RN BACCALAUREATE ☐RN ENTRY-LEVEL MASTERS
(Type of degree or certificate to be conferred or awarded)

The nursing education program was approved by the legal approving authority during the licensure applicant's enrollment. Yes ☐ No ☐

The parent institution is accredited. Yes ☐ No ☐

If Yes, which accreditation agency? _____

The Nursing Program is accredited by a national accreditation agency Yes ☐ No ☐
If Yes, which one? _____

The curriculum covered:

Medical	Theoretical☐	Clinical/Simulation ☐	Not covered☐
Surgical	Theoretical☐	Clinical/Simulation ☐	Not covered☐
Pediatrics	Theoretical☐	Clinical/Simulation ☐	Not covered☐
Obstetrical	Theoretical☐	Clinical/Simulation ☐	Not covered☐
Mental Health	Theoretical☐	Clinical/Simulation ☐	Not covered☐

Was any of this Program completed online? Yes ☐ No ☐
If yes, is the Program authorized to operate by distance education by the legal approving authority in the Parent Institution State? Please list the name of that legal approving authority:

_____

In which state did the graduate complete their clinical rotations (List all):

_____

For PN Programs Only:

Program length (in weeks):	
Total number of program hours including non-nursing requirements	
Total number of hours in nursing courses including: theoretical, lab, simulation and clinical	
Total number of hours allocated to clinical practice (includes lab, simulation, and clinical)	

Program Administrator Name & Credentials (Print): _____

Telephone Number:_____ E-mail: _____

Original Signature of Program Administrator: _____Date: _____

Attestation: By signing this Affidavit, I certify, under the pains and penalties of perjury, that the information provided herein is truthful and accurate.

Send this form with the official final transcript that is in a sealed envelope from the nursing education program the applicant graduated and submit directly to PCS at:

Professional Credential Services
ATN: MA Board of Registration in Nursing
C/O MA Nurse Coordinator
P.O. Box 198788,
Nashville, TN 37219.

AFFIX OFFICIAL SEAL OF NURSING PROGRAM **(Must be raised/embossed)**