



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 LICENSED PRACTICAL AND/OR REGISTERED 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 Instruction: _____ 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Program: Practical Nurse/Vocational Nurse Registered Nurse Withdrawn from RN program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Month/Year Graduated (or withdrawn, if applicable) _____ Length of Program _____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 3721