

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](http://www.mass.gov/dph/boards/rn)

DEVAL L. PATRICK  
GOVERNOR  
JOHN W. POLANOWICZ  
SECRETARY  
CHERYL BARTLETT, RN  
COMMISSIONER

### VERIFICATION OF NURSE LICENSURE

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

#### 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 \_\_\_\_\_ **Course** \_\_\_\_\_ **Clinical** \_\_\_\_\_  
Instruction \_\_\_\_\_ Textbooks \_\_\_\_\_ 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**Program:** ☐ Practical Nurse/Vocational Nurse ☐ Registered Nurse ☐ Withdrawn from RN program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**Month/Year Graduated (or withdrawn if applicable)** \_\_\_\_\_ **Length of Program** \_\_\_\_\_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:*

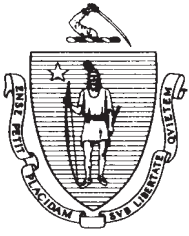
**Professional Credential Services  
ATTN: MA Nurse Coordinator  
P.O. Box 198788  
Nashville, TN 37219**

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**VERIFICATION OF ADVANCED PRACTICE REGISTERED  
NURSE AUTHORIZATION**

*\*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:** \_\_\_\_\_

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