

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

DEVAL PATRICK
GOVERNOR
TIMOTHY P MURRAY
LIEUTENANT GOVERNOR
JUDYANN BIGBY, MD
SECRETARY
JOHN AUERBACH
COMMISSIONER
RULA HARB
EXECUTIVE DIRECTOR

ADVANCED PRACTICE REGISTERED NURSE (APRN) AUTHORIZATION APPLICATION AND INSTRUCTIONS

APRN Authorization Requirements

[Massachusetts General Laws Chapter 112, section 80B & 244 CMR 4.13 & 9.04 (1), (2) and (4) & Licensure Policy 00-01]

1. Valid Massachusetts RN license
2. Good moral character, as established by the Massachusetts Board of Registration in Nursing (Board)
3. Graduation from an APRN education program accredited by a Board-recognized national accreditation body
4. Current advanced practice certification by Board-approved nationally recognized certifying body
5. Payment of all required fees

Important Note: To practice as an APRN in Massachusetts, you must hold current authorization issued by the Board. Temporary authorizations are not issued. An APRN may practice only in the category of advanced practice nursing for which the Board has authorized, (see application for categories).

Carefully read the following information and instructions prior to completing the enclosed applications.

Application for APRN Authorization and Fees

The Board has contracted with Professional Credential Services, Inc. (PCS), Nashville, TN, for the processing of applications, forms, and fees.

Each application for initial, additional or reciprocal authorization must be received by PCS, fully completed and legible, with required documentation, before it will be reviewed. The following documentation must be received for each application for APRN authorization prior to review of the application material:

1. Copy of the applicant's valid Massachusetts Registered Nurse license. APRNs seeking reciprocity must apply for and receive Massachusetts RN licensure prior to applying for APRN authorization.
2. Copy of the applicant's current advanced practice certification by a national certifying organization. The following APRN certifying organizations are those accepted by the Board:
Nurse Practitioners: American Academy of Nurse Practitioners (AANP), American Nurses Credentialing Center (ANCC), National Certification Corporation (NCC), Pediatric Nursing Certification Board (PNCB), American Association of Critical-Care Nurses (AACN);
Psychiatric Nurse Mental Health Clinical Specialists: American Nurses Credentialing Center (ANCC);
Nurse Midwives: American Midwifery Certification Board (AMCB);
Nurse Anesthetists: Council on Certification of Nurse Anesthetists (CCNA).
Review the Board's website www.mass.gov/dph/boards/rn for additional certifying organizations.
3. Applicant's official transcript contained in a sealed envelope sent directly to PCS by the APRN nursing education program the applicant graduated from.
4. If the applicant is licensed as a nurse (LPN and/or RN) in any other state or jurisdiction, verification of licensure status must be completed.
 - For all states that are on the NURSUS License Verifications System:
 - Go to www.nursys.com and follow the instructions including paying the necessary fee. Nursys will post your verification online and it will remain available for 90 days
 - For all states **not** on the NURSUS License Verification System:
 - Complete the authorization portion at the top of page 6 of the attached license verification form;
 - Enclose the appropriate verification fee (*contact the Board of Nursing in that state for fee information*); and
 - Submit directly to the Board of Nursing in that state (*that board will complete and must mail directly to PCS on your behalf*)

5. If the applicant is authorized to practice as an APRN in any other state or jurisdiction, official verification of APRN status from each state or jurisdiction, or both. For each state or jurisdiction:
 - Complete the authorization portion at the top of page 7 of the attached license verification form
 - Enclose the appropriate verification fee (*contact the Board of Nursing in that state for fee information*); and
 - Submit directly to the Board of Nursing in that state (*that board will complete and must mail directly to PCS on your behalf*)
6. If you answer “yes” to any questions related to the good moral character licensure requirement, consult the Board’s *Good Moral Character Licensure Requirement Information Sheet* on the PCS website before submitting application. The Board must determine your compliance with this requirement before authorizing APRN practice.
7. **Important note:** all fees are non-refundable and non-transferable. The application fee must be made by credit card via the attached payment form or money order payable to “PCS”. **No Personal checks!**
 - APRN authorization fee: \$150.00
8. A United States Social Security Number (SSN) is required. Pursuant to M.G.L. c. 30A, s. 13A, the Massachusetts Board of Registration in Nursing is required to obtain your SSN on behalf of the Massachusetts Department of Revenue (DOR). If you do not have a SSN *and are eligible for one*, you must obtain one and provide it to the Board.

Mail the fee, completed application, required application related documents, and all correspondence to:

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

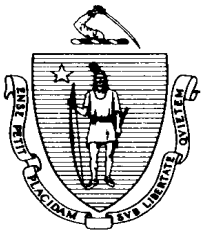
- For confirmation of receipt by PCS, please use certified mail.

What to expect after PCS has received your application, required application related documents and fee:

- Once PCS has received your completed application INCLUDING all required application related documents**, please allow approximately three (3) business days for the review and authorization process
- PCS mails Letter of Authorization within one (1) week of approval
- At the same time letter is mailed, PCS submits notification to the Board electronically
- MA Board posts authorization on their website within 3 business days of PCS notification

Tips for avoiding delays in application and authorization processing:

- Each application for initial, additional or reciprocal APRN authorization must be fully and legibly completed, and include all required documentation received by PCS before being evaluated for compliance with APRN authorization requirements. If incomplete, PCS will notify applicant via email, U.S. mail or phone. **Neither PCS or the Board have control over timely submission of information supplied by third parties.**
- Notify PCS in writing of any change in address occurring between the time of application submission and receipt of authorization. Include name, address, Social Security Number, licensure type (APRN) and, if applicable, examination date, along with the new address. Telephone calls are not accepted for address changes. PCS cannot guarantee that an address change can be made before issuing examination results.
- For issues regarding verification of non-Nursys state RN/PN licensure, the applicant must contact the specific state Board of Registration directly. **PCS has no control over timely submission of verification forms.**
- For issues regarding verification of APRN authorization, the applicant must contact the specific state Board of Nursing directly. **PCS has no control over timely submission of verification forms.**
- Review the *Good Moral Character Licensure Requirement Information Sheet* available at www.pcshq.com. If applicable, submit all required documentation as directed.
- Submission of completed applications and fee acknowledges that the applicant understands and agrees to all provisions herein. Retain copies of all information and completed applications for future reference.
- The Board can not issue you a valid APRN authorization if your current Massachusetts RN license is due to expire within 90 days of authorization approval. You may have to renew early in order to ensure that the time frame for expiration of your Massachusetts RN license exceeds 90 days.



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APPLICATION FOR AUTHORIZATION AS AN ADVANCE PRACTICE REGISTERED NURSE (APRN)

Category Type: *(check only one)* NURSE PRACTITIONER (RN/NP) NURSE ANESTHETIST (RN/NA)
 NURSE MIDWIFE (RN/NM) PSYCHIATRIC NURSE MENTAL HEALTH CLINICAL SPECIALIST (RN/PC)

TYPE OR PRINT USING BLACK INK

UNITED STATES SOCIAL SECURITY NUMBER (SSN) (MANDATORY) _____ - _____ - _____

Pursuant to G.L. c. 30A, s. 13A; see instructions.

NAME _____
 (First) (Middle) (Last) (Maiden /Previous)

DATE OF BIRTH ____/____/____ CITY/STATE/COUNTRY of BIRTH: _____

MOTHER'S MAIDEN NAME _____

HEIGHT: ____ (FT) ____ (IN) WEIGHT: ____ (LBS) EYE COLOR: _____ GENDER: FEMALE MALE

ADDRESS OF RECORD
 (Mailing address) _____
 (No.) (Street) (City) (State or Country) (Zip/Postal Code)

MOST RECENT
 PREVIOUS ADDRESS _____
 (No.) (Street) (City) (State or Country) (Zip/Postal Code)

E-MAIL ADDRESS _____

TELEPHONE NUMBER DAY _____ - _____ - _____ EVENING _____ - _____ - _____

ADVANCED PRACTICE NURSING EDUCATION PROGRAM NAME AND LOCATION: _____

MAJOR AREA OF STUDY: _____ DATES ATTENDED: _____

DEGREE OR CERTIFICATE AWARDED: _____ DATE: _____

NAME OF NATIONAL CERTIFYING BODY: _____ AREA OF CERTIFICATION: _____

CERTIFICATION NUMBER: _____ DATE GRANTED: _____ EXPIRATION DATE: _____

DO YOU CURRENTLY HOLD OR HAVE YOU PREVIOUSLY HELD AUTHORIZATION TO PRACTICE AS AN APRN IN MASSACHUSETTS? IF YES, INDICATE CATEGORY/CATEGORIES:

RN/NP RN/NA RN/PC RN/NM

If you have ever been licensed as a Registered Nurse or Practical Nurse in the United States or its territories, please arrange for submission of Licensure Verification Form or NURSUS Form, as applicable, from each state or jurisdiction (including Massachusetts) in which you are, or have been, licensed as a Nurse. Form must indicate the status of your license and any disciplinary action (refer to instructions). **The Board can not issue you a valid APRN authorization if your current MA RN license is due to expire within 90 days of authorization approval. You may have to renew early in order to ensure that the time frame for expiration of your MA RN license exceeds 90 days.** Note: MA is a NURSUS participating state.

State	License Number	Issue Date	State	License Number	Issue Date

If you have ever been authorized to practice as an APRN in the United States or its territories, please arrange for submission of Authorization Verification Form, as applicable, from each state or jurisdiction. Form must indicate the status of your authorization and any disciplinary action (refer to instructions).

State	License Number	Issue Date	State	License Number	Issue Date

If necessary, continue on another sheet of paper. Please be sure not to omit any states, or your application will be returned to you.

QUESTIONS: If you answer “yes” to any of the following questions, the Board must evaluate your compliance with the good moral character licensure requirements. This evaluation must be completed to determine your qualifications for APRN authorization in Massachusetts. Prior to submitting this licensure by examination application, refer to the Board’s *Good Moral Character Licensure Requirement Information Sheet* for directions. Review the Information Sheet carefully. Submit all required documentation to the Board as directed.

		YES	NO
1.	Has any disciplinary action ever been taken against you by a professional and/or trade licensing/certification board located in the United States or any country/foreign jurisdiction, including removal from a long-term care nurse aide registry program?		
2.	Are you the subject of pending disciplinary action by a professional and/or trade licensing/certification board located in the United States or any country/foreign jurisdiction?		
3.	Have you ever applied for, and been denied, a professional and/or trade license/certification in the United States or any other country/foreign jurisdiction?		
4.	Have you ever surrendered or resigned a professional and/or trade license/certificate in the United States or any other country/foreign jurisdiction?		
5.	Have you ever been convicted of a felony or misdemeanor in the United States or any other country/foreign jurisdiction?		
6.	Are you the subject of any pending or open criminal case (s) or investigation(s), (including for any felony or misdemeanor) in a jurisdiction in the United States or any country/foreign jurisdiction?		

ATTESTATION: By signing this application for APRN authorization, I certify, under the pains and penalties of perjury, that:

- The information that I have provided in connection with this application is truthful and accurate;
- I understand that the failure to provide truthful and accurate information may be grounds for the Massachusetts Board of Registration in Nursing (Board) to deny me APRN authorization in accordance with Massachusetts law;
- I have read and understand the Board’s Good Moral Character Licensure Requirement Information Sheet;
- I understand that the Board is certified by the Massachusetts Criminal History Systems Board (CHSB) for access to conviction and pending criminal case data (Agency Code: MABRN G). As an applicant for APRN authorization, I understand that a criminal record check **may be** conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information provided in this application pursuant to 803 CMR 3.05 is correct to the best of my knowledge;
- I understand that this application is void if requirements for APRN authorization are not met within one (1) year from the date of Board receipt of the application. I also understand that fees are non-refundable and non-transferable; and
- If I am granted APRN authorization by the Board, I will comply with the Board regulations at 244 CMR 3.00 – 9.00.

Signature of Applicant

Date

ATTACH A RECENT
2x2 COLOR PASSPORT
PHOTO HERE

APPLICANT FACE ONLY

SIGN PHOTO

Mail Application for APRN Authorization to:
Professional Credential Services
ATTN: MA Nurse Coordinator
P.O. Box 198788
Nashville, TN 37219

Questions or Comments, contact PCS at:
Toll-free: (877) U-TRY-PCS
Web site: <http://www.pcshq.com>
Email: aprn@pcshq.com

P.O. Box 198788
Nashville, TN 37219

Payment Form

Two payment options are available: Money Order or Credit Card.

Applicant Name: _____
Social Security Number (Mandatory): _____ - _____ - _____

Fees are non-refundable and non-transferable.

Advance Practice Authorization Application Fee: \$150.00

Please check form of payment below:

- Money Order (*Please ensure the applicant's name is on the payment*)

If paying by Money Order, please make it payable to "PCS" for the total amount of the APRN authorization(s) you are applying for.

Or

- Credit Card

Authorized payment amount: \$ _____ Please check one: Visa MasterCard

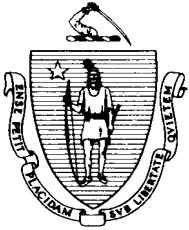
Card Number: _____ - _____ - _____ - _____ Exp: _____ / _____

Print name as it appears on account: _____

Authorized Signature: _____

Return this payment form with Application Form. DO NOT staple your payment to this form.

Note: *This document will be shredded after it has been processed.*



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VERIFICATION FORM FOR LICENSURE AS A REGISTERED NURSE

APPLICANT: COMPLETE THIS SECTION ONLY

I, _____, RN 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

Applicant Name as Appearing on Original License _____

Applicant Name as Appearing on Current License _____

School of Nursing _____

Location _____

Year Graduated _____ Length of Program _____ Board Approved: Yes No

Language of nursing instruction _____ Language of nursing textbooks _____

Type of Program: Certificate Diploma Associate Degree Baccalaureate Degree

Applicant Registration Number _____ Date of Original Issue _____

Current Licensure Status: Active Inactive Lapsed Expiration Date _____

Method of Licensure (Check One) Examination Waiver Reciprocity

Type Of Exam: SBTPE NCLEX Exam Date _____
 (If Examination Other Than Above, Provide Test Name And Scores On Back Of This Form.)

Has License Ever Been Disciplined? Yes No
 (If "Yes" Please 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.

Signature of Authorized Person _____

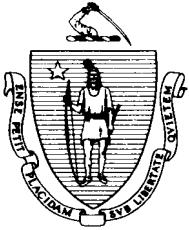
AFFIX OFFICIAL STATE SEAL

Title _____ Date _____

State _____

Mail this form to:

**Professional Credential Services
 Attn: MA Nurse Coordinator
 PO Box 198788, Nashville, TN 37219**



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**VERIFICATION FORM FOR
 ADVANCED PRACTICE REGISTERED NURSE
 AUTHORIZATION**

APPLICANT: COMPLETE THIS SECTION ONLY

I, _____, APRN License Number _____, am applying to the Massachusetts Board of Nursing for Advance 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

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: Active Inactive Lapsed Expiration Date _____

Method of Authorization: (Check One) Original Waiver Reciprocity

National Certification by: _____ Exam Date: _____

Has License Ever Been Disciplined? Yes No

(If "Yes" Please 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.

Signature of Authorized Person _____

AFFIX OFFICIAL STATE SEAL

Title _____ Date _____

State _____

Mail this form to:

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 Attn: MA Nurse Coordinator
 PO Box 198788
 Nashville, TN 37219**