

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

**LICENSURE BY RECIPROCITY INFORMATION AND  
INSTRUCTIONS FOR REGISTERED NURSES  
EDUCATED AND LICENSED IN CANADA**

**I. General licensure by reciprocity information**

Nurse Licensure Requirements (M.G.L. chapter 112, sections 74, 74A, 76B, 81B and 81C, and 244 CMR 8.00)

1. Graduation from a Registered Nurse (RN) education program approved by the Massachusetts Board of Registration in Nursing (Board). Graduates of a nursing education program whose language of instruction and/or textbooks was not English must demonstrate English proficiency; see section II below.
2. Licensure as a Registered Nurse in Canada. Applicants licensed by the Canadian Nurses Association Testing Service (CNATS) Examination or CNATS Comprehensive Exam in French must demonstrate English proficiency; see section II below.
3. Achievement of a score as indicated in *one of the following* examinations:
  - a passing score on the State Board Testing Pool Examination prior to August 1, 1970; or
  - a score greater than 400 in each component of the CNATS between August 1, 1970 and August 1, 1980; or
  - a score greater than 400 on the CNATS Comprehensive examination between August 1, 1980 and August 1, 1995\*.
4. Good moral character as established by the Board.
5. Payment of all required fees.

\*Applicants who wrote the CNATS exam after August 1, 1995, are not eligible for reciprocity. Contact the Board's credential review service, Professional Credential Services, Inc., at (877) 887-9727 to request an *Application For Certification Of Graduation From A Board-Approved Nursing Education Program Located In Canada* and an *Application For Initial Licensure As A Nurse By Examination Information and Instructions*.

**Important notes:** To practice nursing in Massachusetts, you must hold a valid, current Massachusetts license issued by the Board. "Temporary" licenses are not issued.

Federal law requires non-US educated health care professionals to successfully complete a screening program before receiving an occupational visa. This screening requires nurses to have earned either an International Commission on Health Professionals VisaScreen™ Certificate (applicable to RN licensure only) or have passed the National Council Licensure Examination for Registered Nurses (NCLEX-RN). Canadian RNs, previously licensed in Massachusetts by reciprocity of their Canadian RN, are not eligible to apply to the Board to write the NCLEX-RN.

**II. Education and English proficiency requirements for graduates of nursing education programs located outside the United States and its territories**

1. The Board requires graduation from an RN education program approved by the nursing board or corresponding body in the province of Canada where the applicant was licensed as a Registered Nurse by examination (CNATS Examination or CNATS Comprehensive Examination).
2. The Board requires evidence of English proficiency if you were a graduate of a nursing education program whose language of instruction or textbooks was not English, or took the CNATS Examination or the CNATS Comprehensive Examination in French. To meet the Board's English proficiency requirement, you must achieve:
  - a minimum score of 550 (paper-based examination) or 213 (computer-based examination) or 79/80 (internet-based examination) on the Test of English as a Foreign Language (TOEFL); **or**
  - a Pass score on the English portion of the Commission on Graduates of Foreign Nursing Schools (CGFNS) Qualifying Examination as evidenced by a CGFNS Qualifying Examination Certificate *issued before July 15, 1998*.

### III. Applying for RN licensure by reciprocity of your Canadian RN license

#### 1. Apply for Licensure as a Registered Nurse by Reciprocity – Canadian Registered Nurse

Complete the attached *Application for Licensure as a Registered Nurse by Reciprocity For Registered Nurses Educated and Licensed in Canada*, including the “good moral character” related questions. Enclose the \$275.00 non-refundable, non-transferable administrative processing fee (payment can be made by Visa or MasterCard, or money order made payable to PCS). Submit application and fee to the Board’s credentials review service, Professional Credential Services, Inc.

#### 2. Provide supporting documentation

a. Complete the Applicant Information section of the Verification of Nurse Licensure, and forward to the licensing authority in each Canadian province in which you are a licensed nurse.

b. Have one of the following submitted:

- Certificate of Graduation (form attached)
- CGFNS Qualifying Examination Certificate with CGFNS emboss (RN licensure only)
- VisaScreen™ Certificate with International Commission on Health Professions emboss (RN licensure only)
- CGFNS Credentials Evaluation Report, including both the Nursing and Science Course-by-Course Report and License/Registration validation option, with CGFNS emboss (RN and PN licensure) or CES Report posted at the CGFNS website for PCS access.

#### 3. If applicable, demonstrate English proficiency

Have one of the following submitted directly to PCS (copies will **not** be accepted):

- CGFNS Qualifying Examination Certificate issued **before** July 15, 1998
- *TOEFL Official Score Report*

#### **CGFNS**

3600 Market Street, Suite 400  
Philadelphia, PA 19104-2651  
Phone: (215) 349-8767  
Internet: [www.cgfns.org](http://www.cgfns.org)

#### **TOEFL**

Educational Testing Services  
P.O. Box 6151  
Princeton, NJ 08541-6151  
Phone: (609) 771-7100 [www.toefl.org](http://www.toefl.org)  
(MA Board of Nursing TOEFL Code #9229)

### IV. Important information regarding Social Security Numbers (SSN)

A U.S. Social Security Number 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). The DOR will use your SSN to ascertain whether you are in compliance with Massachusetts laws relating to taxes and child support. If you do not have a SSN *and are eligible for one*, you must obtain one and provide it to the Board. If you are not eligible for a SSN, you must complete the Board’s Affidavit in Support of Application for License to Practice as a Registered Nurse and attach the completed affidavit to this application. For complete SSN information, contact the U.S. Social Security Administration at 800-772-1213, or [www.ssa.gov](http://www.ssa.gov).

#### **SUBMIT APPLICATION, PAYMENT, AND ALL CORRESPONDENCE TO:**

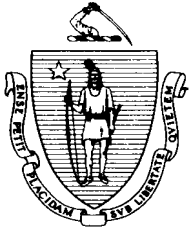
**Professional Credential Services, Inc.  
ATTN: MA Reciprocity Nursing  
P. O. Box 198788  
Nashville, TN 37219**

**Application inquiries should be directed to:**

[nursebyreciprocity@pcshq.com](mailto:nursebyreciprocity@pcshq.com)

**or toll free at 877-887-9727**

Applications are reviewed only after **all** required forms are received. Licensure is granted based on the applicant’s compliance with the above eligibility requirements. A license to practice nursing in the Commonwealth will be mailed to you approximately 15 business days after the application has been approved by the Massachusetts Board’s credential review service, Professional Credential Services (PCS).



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**APPLICATION FOR LICENSURE BY RECIPROCITY  
 FOR REGISTERED NURSES  
 EDUCATED AND LICENSED IN CANADA**

**For Board use only**

NURSYS by:	Approved by:	License No:
Date:	Date:	Issued:

**SOCIAL SECURITY NUMBER (SSN) (MANDATORY)** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Pursuant to G.L. c. 30A, s. 13A; see instructions.

**NAME** \_\_\_\_\_  
 (First) (Middle) (Last) (Maiden /Previous)

**DATE OF BIRTH** \_\_\_\_/\_\_\_\_/\_\_\_\_ **PLACE OF BIRTH** \_\_\_\_\_ **GENDER: FEMALE**  **MALE**

**HEIGHT** \_\_\_\_ (FT) \_\_\_\_ (IN) **WEIGHT** \_\_\_\_ (LBS) **EYE COLOR** \_\_\_\_\_

**MOTHER'S MAIDEN NAME** \_\_\_\_\_

**ADDRESS OF RECORD**  
 (current 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** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**NURSING EDUCATION PROGRAM NAME AND LOCATION:** \_\_\_\_\_

**LANGUAGE OF NURSING INSTRUCTION** \_\_\_\_\_ **LANGUAGE OF NURSING TEXTBOOKS** \_\_\_\_\_

**GRADUATION DATE** \_\_\_\_ / \_\_\_\_  
 month year **DEGREE EARNED:**  RN Diploma  Bachelor of Science in Nursing  
 Associate Degree in Nursing  RN Entry-level Masters

**STATE/PROVINCE OF ORIGINAL RN LICENSURE** \_\_\_\_\_

**ORIGINAL LICENSE NUMBER** \_\_\_\_\_ **YEAR ISSUED** \_\_\_\_\_

If you have ever been licensed as a Practical/Vocational Nurse or Registered Nurse in the United States or its territories, please arrange for submission of Licensure Verification Form or register on [www.Nursys.com](http://www.Nursys.com), as applicable, from each state or jurisdiction (**including Massachusetts**) in which you are, or have been, licensed as a Practical/Vocational Nurse or Registered Nurse. Form must indicate the status of your license and any disciplinary action.

Please provide the following information regarding any nurse license you currently or previously held:

TERRITORY or PROVINCE	PROFESSION	TYPE (license or certificate)	LICENSE NUMBER	DATE ISSUED	STATUS (current or expired)

If necessary, continue on another sheet of paper. Please be sure not to leave any 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 initial licensure by reciprocity in Massachusetts. Prior to submitting this licensure by reciprocity 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 nurse licensure by reciprocity, 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 nurse licensure 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 initial nurse licensure by reciprocity, 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 nurse licensure by reciprocity 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 nurse licensure by the Board, I will comply with the Board regulations at 244 CMR 3.00 – 9.00.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

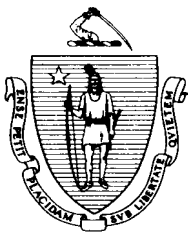
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RECENT  
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COLOR PASSPORT  
PHOTO HERE

APPLICANT FACE  
ONLY

Mail Application for Licensure to:

**Professional Credential Services  
ATTN: MA Reciprocity Nursing  
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: [nursebyreciprocity@pcshq.com](mailto:nursebyreciprocity@pcshq.com)



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**CERTIFICATION OF GRADUATION FROM A BOARD-APPROVED  
 REGISTERED NURSING EDUCATION PROGRAM  
 LOCATED IN CANADA**

**APPLICANT: PLEASE COMPLETE THIS SECTION ONLY (TYPE OR PRINT)**

Applicant name \_\_\_\_\_  
 (Last) (First) (Middle) (Maiden/other)

Address of Record \_\_\_\_\_  
 (No. and Street) (City) (Province) (Country) (Postal Code)

Telephone \_\_\_\_\_ US SSN \_\_\_\_\_  
 (see application information for instructions)

RN Number (if applicable) \_\_\_\_\_

I, \_\_\_\_\_, am applying to the Massachusetts Board of Registration in Nursing for eligibility for licensure. I hereby authorize you to furnish to the Massachusetts Board of Registration in Nursing the information requested below.

\_\_\_\_\_  
 (Date) (Signature of applicant) (Province issued)

**NURSING EDUCATION PROGRAM ADMINISTRATOR: PLEASE COMPLETE THIS SECTION**

Name of applicant \_\_\_\_\_

Nursing education program \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Date of admission \_\_\_\_\_ Date of graduation \_\_\_\_\_

Language of nursing instruction \_\_\_\_\_ Language of nursing textbooks \_\_\_\_\_

Nursing education program was government-approved at the time of graduation?  Yes  No

Nursing education program is offered at the post-secondary education level?  Yes  No

Program offers:  Diploma  AD  BSN  Direct-entry MSN

Program length: \_\_\_\_\_

Nursing theory included:  Medical  Surgical  Obstetrical  Pediatric  Psychiatric/Mental Health

Nursing clinical included:  Medical  Surgical  Obstetrical  Pediatric  Psychiatric/Mental Health

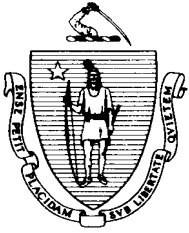
**Affix Official Seal**

Once completed, please return this form to:  
**Professional Credential Services**  
**ATTN: MA Nursing by Exam**  
**P.O. Box 198788**  
**Nashville, TN 37219**

I certify the above to be a true report for the named nurse according to records in this office.

Signature of authorized person \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_



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**VERIFICATION OF NURSE LICENSURE  
 BY CANADIAN PROVINCE OR TERRITORY**

**APPLICANT: PLEASE COMPLETE THIS SECTION ONLY (TYPE OR PRINT)**

Applicant name \_\_\_\_\_  
 (Last) (First) (Middle) (Maiden/other)

Address of Record \_\_\_\_\_  
 (No. and Street) (City) (Province) (Country) (Postal Code)

Telephone \_\_\_\_\_ US SSN \_\_\_\_\_  
 (see application information for instructions)

RN/PN Number (if applicable) \_\_\_\_\_

I, \_\_\_\_\_, am applying to the Massachusetts Board of Registration in Nursing for eligibility for licensure. I hereby authorize you to furnish to the Massachusetts Board of Registration in Nursing the information requested below.

\_\_\_\_\_  
 (Date) (Signature of applicant) (Province issued)

**PROVINCIAL/TERRITORIAL LICENSING AUTHORITY: PLEASE COMPLETE THIS SECTION**

Canadian licensee's name as appearing on original license \_\_\_\_\_

Canadian licensee's name as appearing on current license \_\_\_\_\_

Nursing education program from which Canadian licensee graduated \_\_\_\_\_

Address \_\_\_\_\_ Year graduated \_\_\_\_\_  
 (Province) (Country)

Type of Program:  Certificate  Diploma  Associate Degree  Baccalaureate Degree

Type of Licensure:  First-level general (Registered Nurse)  Secondary-level general (Practical Nurse)

Licensee's Registration Number \_\_\_\_\_ Date of original issue \_\_\_\_\_

Method of Licensure (check one):  Examination  Waiver  Exam Series CNATS Score \_\_\_\_\_

Score: Medical \_\_\_\_\_ Psychiatric \_\_\_\_\_ Obstetrics \_\_\_\_\_ Nursing \_\_\_\_\_ Children \_\_\_\_\_

Was the Exam written in English?  Yes  No (If examination other than above, provide test name and scores on back of this form.)

Has the named nurse ever been disciplined and/or is the nurse currently under investigation?  Yes  No (If yes, provide explanation on back.)

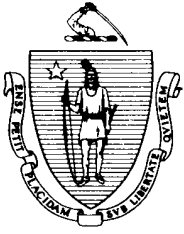
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Once completed, please return this form to:  
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**ATTN: MA Nursing by Exam**  
**P.O. Box 198788**  
**Nashville, TN 37219**

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 \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_



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**AFFIDAVIT IN SUPPORT OF APPLICATION FOR  
 LICENSURE TO PRACTICE AS A REGISTERED NURSE**

Full name: \_\_\_\_\_  
 (Last) (First) (Middle) (Maiden/Previous)

Address: \_\_\_\_\_  
 (No.) (Street) (City) (State/Country) (Zip/Postal Code)

Date of Birth: \_\_\_\_\_

1. In accordance with regulations of the Massachusetts Board of Registration in Nursing (Board), I will inform the Board within thirty (30) days of any change in my address.
2. The Board is required by law (MGL c. 30A, s. 13A) to report to the Massachusetts Department of Revenue the Social Security Number of every applicant for a nursing license. In conformance with the Department of Revenue's interpretation of this legal requirement, by signing below I certify that I have not been issued a Social Security Number and that I am ineligible to receive a Social Security Number at this time.
3. As soon as I become eligible, I will apply for a Social Security Number. Immediately upon my receipt of a Social Security Number, I will provide to the Board, in writing at the address listed above, my valid Social Security Number and a copy of my Social Security card, or any other document issued by the Social Security Administration, as evidence of my Social Security Number.
4. I understand that my failure to provide my valid Social Security Number to the Board within ten (10) days of receipt and/or the submission of false information to the Board in connection with this Affidavit shall constitute sufficient grounds for the Board to take disciplinary action against my nursing license.
5. I understand that if I fail to supply my valid Social Security Number to the Board before my Massachusetts nursing license expires, the Board shall not renew my license until I provide my valid Social Security Number and, under such circumstances, I hereby WAIVE my right to renew my license until such time as I have provided my valid Social Security Number to the Board.

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

\_\_\_\_\_  
 Signature of Applicant (Date) Name of Applicant (Print)



P.O. Box 198788  
Nashville, TN 37219

**APPLICATION FOR LICENSURE BY RECIPROCITY  
FOR REGISTERED NURSES  
EDUCATED AND LICENSED IN CANADA**

**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.**

**LICENSURE BY RECIPROCITY FEE: \$275.00**

*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."

**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.*