



# 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)

## VERIFICATION OF ADVANCED PRACTICE REGISTERED NURSE AUTHORIZATION

### APPLICANT: COMPLETE THIS SECTION ONLY

I, \_\_\_\_\_,  CNP  CNM  CRNA  PCNS  CNS  
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: \_\_\_\_\_

Affix Board Seal

Mail to:

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