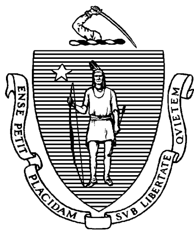

The Commonwealth of Massachusetts

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 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 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Program: ☐ **Practical Nurse/Vocational Nurse** ☐ **Registered Nurse** ☐ **Withdrawn from RN program**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Month/Year Graduated (or withdrawn, if applicable)______________ **Length of Program**__________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 Reciprocity Nursing
P.O. Box 198788
Nashville, TN 37219