

The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

Bureau of Health Professions Licensure

Board of Registration in Nursing

www.mass.gov/dph/boards/rn

CERTIFICATION OF GRADUATION FROM AN OUT OF STATE NURSING EDUCATION PROGRAM

To be completed by Program Administrator, (the Registered Nurse designated the administrative authority and responsibility for the nursing education program), for all graduates of nursing education programs located outside of Massachusetts in the U.S. or its territories that are applying for initial licensure by examination and reciprocity licensure in Massachusetts.

- A Board-issued NCLEX Eligibility Certificate must be attached to the *Application for Initial Nurse Licensure by Examination and Reciprocity Licensure* for graduates of non-U.S. nursing education programs.
- A Board-issued NCLEX-PN Eligibility Certificate must be attached to the *Application for Initial Nurse Licensure by Examination and Reciprocity Licensure* for former RN nursing education program students withdrawn in good standing who meet PN curriculum requirements.

I hereby certify that

(Applicant's Name/Year of Birth)

First

Middle

Last

Year of Birth

graduated from

(Nursing Education Program)

Located

(City/Town)

(Zip/Postal Code)

Date of Graduation***Date Degree or Certificate conferred/awarded**

(*244 CMR 8.01; Graduation means the date the applicant graduated from a nursing education program as defined in the policy of the applicant's nursing education program).

Program Type

Check one *

☐ PRACTICAL/VOCATIONAL NURSE☐ RN BACCALAUREATE☐ RN DIPLOMA

ORN ENTRY-LEVEL MASTERS

☐ RN ASSOCIATE DEGREE☐ RN ENTRY-LEVEL DOCTORATE

(Type of degree or certificate to be conferred or awarded)

The nursing education program was approved by the legal approving authority during the licensure applicant's enrollment. Yes ☐ No ☐

Program Approval Status

Agency:	
Last Review:	
Outcome:	
Next Review	Date <input type="text"/> Ongoing <input type="checkbox"/>

The parent institution is accredited. Yes ☐ No ☐

(**244 CMR 10:** Parent Institution Accreditation means the formal recognition or acceptance of the parent institution by a regional or professional accrediting agency recognized by the United States Department of Education or other Board recognized entity.)

Parent Institution Accreditation Status

Agency:	
Last Review:	
Outcome:	
Next Review:	

The Nursing Program has candidacy from a national accreditation agency? Yes ☐ No ☐

(244 CMR 10: Program Accreditation Candidacy means the formal recognition or acceptance of the nursing education program's potential to achieve program accreditation by a Board Recognized Accrediting Agency in Nursing.)

If Yes, which one?

1. Accreditation Commission for Education in Nursing (ACEN) ☐
2. Collegiate Nursing education (CCNE) ☐
3. National League for Nursing Commission for Nursing Education Accreditation (NLN CNEA) ☐

The Nursing Program is accredited by a national accreditation agency? Yes ☐ No ☐

(244 CMR 10: Program Accreditation means the formal recognition or acceptance of the nursing education program by a Board Recognized Accrediting Agency in Nursing.)

If Yes, which one?

1. Accreditation Commission for Education in Nursing (ACEN) ☐
2. Collegiate Nursing education (CCNE) ☐
3. National League for Nursing Commission for Nursing Education Accreditation (NLN CNEA) ☐

Program Approval Status

Last Review:	
Outcome:	
Next Review:	

The curriculum covered:

Medical/Surgical	Theoretical <input type="checkbox"/>	Clinical <input type="checkbox"/>	Simulation <input type="checkbox"/>	Not covered <input type="checkbox"/>
Pediatrics	Theoretical <input type="checkbox"/>	Clinical <input type="checkbox"/>	Simulation <input type="checkbox"/>	Not covered <input type="checkbox"/>
Obstetrical	Theoretical <input type="checkbox"/>	Clinical <input type="checkbox"/>	Simulation <input type="checkbox"/>	Not covered <input type="checkbox"/>
Mental Health	Theoretical <input type="checkbox"/>	Clinical <input type="checkbox"/>	Simulation <input type="checkbox"/>	Not covered <input type="checkbox"/>

For Clinical hours:

Based on the Program's approved credited clinical hours in the below content areas, please delineate the percentage of clinical hours in (see definitions p.3):

1. Direct Patient Care
2. High Fidelity Simulated Experiences
3. Virtual Simulated Experience
4. Other learning opportunities such as case studies, care plans and/or care mapping

Totals percentage for each course/content area should equal 100%.

Course/Content	Direct Patient Care (Traditional Clinical Experience)	High Fidelity Simulation	Virtual Simulated Experience	Other learning	Total
Medical/Surgical					100%
Pediatrics					100%
Obstetrics					100%
Mental Health					100%

Traditional Clinical Experience: Practice in an inpatient, ambulatory care or community setting where the student provides care to patients under the guidance of an instructor or preceptor.(NCSBN, 2016) **Simulation:** A technique, not a technology, to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner (NCSBN, 2016). **Virtual Simulation:** "The term is often used to describe a variety of interchangeable learning modalities,

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including three-dimensional learning environments (Hansen, 2008), virtual or augmented reality (Kardong-Edgre et al. 2019), game-based learning, and screen-based learning." (Martin et al, 2023)

Was any of this Program completed online as the **standard method** of delivery? Yes ☐ No ☐

If yes, is the Program authorized to operate by distance education by the legal approving authority in the Parent Institution's State? Yes ☐ No ☐

Please list the name of that legal approving authority:

Did the graduate complete any of their clinical rotations in Massachusetts Yes ☐ No ☐ If yes (List all):

TYPE (Fundamental, Med/Surg, Pedi, Ob, Psych, Community, Preceptorship)	CLINICAL AGENCY	DATES

For PN Programs Only:

Program length (in weeks):	
Total number of program hours including non-nursing requirements	
Total number of hours in nursing courses including: theoretical, lab, simulation and clinical	
Total number of hours allocated to clinical practice	

Program Administrator Name & Credentials (Print): _____

Telephone Number: _____ E-mail: _____

Original Signature of Program Administrator: _____ Date: _____

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

Send this form with the official final transcript that is in a sealed envelope from the nursing education program where the applicant graduated and submit directly to PCS at:

**Professional Credential Services
ATN: MA Board of Registration in Nursing
C/O MA Nurse Coordinator
P.O. Box 198788,
Nashville, TN 37219.**

***AFFIX OFFICIAL NURSING PROGRAM or
SCHOOL seal (Must be raised/embossed)***