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

ATTESTATION FOR GRADUATION FROM A CLOSED OUT OF STATE NURSING EDUCATION PROGRAM

*To be completed by the Holder of Records for all graduates of nursing education programs located outside of Massachusetts in the U.S. or its territories that **CLOSED** prior to **May 26, 2023,** who are applying for initial licensure by examination and reciprocity licensure in Massachusetts.*

I hereby certify that _____
(**Applicant's Name/Year of Birth**) (**First**) (**Middle**) (**Last**) (**Year of Birth**)

graduated from _____
(Nursing Education Program Name)

Located _____
(Address) **(City/Town)** **(State, Zip/Postal Code)**

Date of Graduation* _____ **Date Degree or Certificate was 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).

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

Program Type Check one *

☐ PRACTICAL/VOCATIONAL NURSE ☐RN DIPLOMA ☐RN ASSOCIATE DEGREE
☐RN BACCALAUREATE ☐RN ENTRY-LEVEL MASTERS ☐RN ENTRY-LEVEL DOCTORATE
☐RN OTHER _____

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

Agency:	
Last Review:	
Outcome:	

The parent institution was accredited during the licensure applicant's enrollment. 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.)

Agency:	
Last Review:	
Outcome:	

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

Name (print):_____ Title: _____

Signature:_____ Date: _____

Submit this form with the official final transcript 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.