



The Commonwealth of Massachusetts
 Department of Public Health
Bureau of Health Professions Licensure
 239 Causeway Street • Suite 500, 5th Floor • Boston • MA • 02114
<http://www.mass.gov/dph/boards/rn>
 (617) 973-0900

Board of Registration in Nursing

Use this form to request a name change, address change and/or a duplicate RN, LPN or APRN license. Check all that apply:

- NAME CHANGE** **ADDRESS CHANGE** **DUPLICATE LICENSE**

Read the following information carefully before completing form:

1. If you are requesting a **name change** and you have a current or expired license with another board within the Bureau, the requested name change will be effective for all boards.
2. All addresses are subject to disclosure on request (MGL c. 4, s. 7).
3. A **duplicate** license can NOT be issued to you during the three (3) months before your license expiration date (RN renewal: licensee's birthday in even-numbered years. LPN renewal: licensee's birthday in odd-numbered years).
4. You must complete this form and **remit the duplicate license fee for each license** you wish to have duplicated.
5. **Advanced Practice Registered Nurses (APRN):** When requesting a duplicate APRN license, DO NOT request a duplicate RN license. Your APRN license includes both your APRN authorization category and your current licensure as an RN.

For a name change, you **MUST** return the original hard copy of your nursing license and submit photocopies of supporting documents. Check document submitted: marriage certificate divorce decree court documents

If unable to submit hardcopy of your nursing license check here if your current license has been **lost or stolen** .

License Number: RN _____ **LPN** _____ **Expiration Date:** _____

APRN category (if applicable, check one): CRNA CNM CNP PCNS CNS

Social Security Number (Mandatory): _____ **Date of Birth:** _____

Clearly print or type information as it <u>NOW APPEARS</u> on your license: Name: _____ Address: _____ City/Town: _____ State: _____ Zip code: _____	Clearly print or type information as you wish it to appear on your <u>NEW</u> license: Name: _____ Address: _____ City/Town: _____ State: _____ Zip code: _____
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Other professional licenses held (check all that apply):
 Dentistry Genetic Counselor Nursing Home Administrator Perfusionist Pharmacy Physician Assistant Respiratory Care

My signature hereon attests under penalties of perjury that the information provided is truthful, complete, and for lawful and honest purposes.

Signature: _____

Daytime Telephone Number: _____

Date: _____

Mail request to the Board at the address above.

FEE(S)	
1. Duplicate license	\$17.00
2. Name change with new license	\$27.00
3. Address changes only	No Fee
4. Name change	No Fee
Make check or money order payable to the "Commonwealth of Massachusetts." DO NOT SEND CASH OR ELECTRONIC FUNDS TRANSERS	

<u>For Official Use Only:</u>	
Check Amount (fee):	_____
Check Number:	_____
MLO Receipt Date:	_____
MLO Receipt Number:	_____
Staff Signature:	_____