The Commonwealth of Massachusetts
Department of Public Health
Bureau of Health Professions Licensure
250 Washington Street • 3rd Floor • Boston • MA• 02108
http://www.mass.gov/dph/boards/rn
(617) 973-0900

Board of Registration in Nursing

The Board of Registration in Nursing (Board) will no longer issue paper license renewal reminders or paper licenses beginning with the 2018 renewal period. The Board will use email to communicate renewal reminders and important changes in statute, regulations and policies related to nursing. **FAILURE TO PROVIDE A WORKING EMAIL ADDRESS WILL PREVENT YOU FROM RECEIVING THESE IMPORTANT UPDATES**. Log onto the Online Services link at www.mass.gov/dph/boards/rn to add or change your postal or email address. The data base does not work w/iPhones, iPads, Safari or Google Chrome. Please use a compatible web browser. Online changes are processed in real time. Paper requests may take up to 14 days to complete once received.

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

☐ **NAME CHANGE** ☐ **ADDRESS CHANGE** ☐ **EMAIL ADDRESS CHANGE**

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).

For a name change, you **MUST** submit photocopies of supporting documents.

Check document submitted: __marriage certificate __ divorce decree __ court documents

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 **NOW APPEARS** on your current license:	Clearly print or type information as you wish it to appear on your **NEW** license:
Name:_____	**Name**:_____
Address: _____	**Address**: _____
City/Town: _____	**City/Town**: _____
State: _____ **Zip code:** _____	**State**: _____ **Zip code:** _____
	Email Address:

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: _____