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
250 Washington Street, 3rd Floor, Boston, MA 02108
617-973-0900 617-973-0895 TTY

Name: _____ Date: _____

Address: _____

License Number: _____ Exp. Date: __ / __ / __

Email address: _____
(must be legible)

Request to Make "Current" Advanced Practice Registered Nurse Authorization

Advanced Practice Registered Nurse (APRN) category requested to become "current":

Nurse Anesthetist (CRNA) ☐ Nurse Practitioner (CNP) ☐ Nurse Midwife (CNM) ☐
Psychiatric Clinical Nurse Specialist (PCNS) ☐ Clinical Nurse Specialist (CNS) ☐

Authorization to Obtain Information

I authorize the MA Board of Registration in Nursing to obtain substantiating information from

_____ _____ for the purpose of verification.
(Professional Certifying Organization Name) **(Certification #)**

I understand that I must satisfy all Board requirements prior to receiving Board authorization to practice as an APRN in MA. (Ref: 244 CMR 4.00)

My signature attests under penalties of perjury to the best of my knowledge and belief, I have complied with:

1. State tax and child support laws.
2. Mandatory reporting laws including my obligations to report the abuse or neglect of children (MGL c. 119, s. 51A); and
3. Board laws and regulations, including continuing education regulations.

Enclose non-fundable fee of $117.00. (write License # on check made payable to: Commonwealth of MA)

_____ _____
Signature Date