The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division 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: _____

SSN: _____ Date of Birth: __ / __ / __ License Number: _____ Exp.Date: _____

Request to Remove Advanced Practice Registered Nurse Authorization

Advanced Practice Registered Nurse Authorized Category (APRN) to be removed:

Nurse Anesthetist (RN/NA) ☐ Nurse Practitioner (RN/NP) ☐
Nurse Midwife (RN/NM) ☐ Psychiatric CNS (RN/PC) ☐
Clinical Nurse Specialist (RN/CNS) ☐

Reason for requesting removal of APRN Authorization:

I no longer intend to practice in this APRN category ☐
I am no longer certified in this APRN category ☐
I am retired ☐
I have changed career plans/goals ☐
Other ☐ (please specify) _____

I understand that by signing and submitting this request, I am asking the Massachusetts Board of Registration in Nursing (Board) to remove my authorization to practice as an APRN in the Commonwealth of Massachusetts. Further, I understand that if, and when I wish to request reinstatement of my authorization that I will be required to complete the APRN application process including the payment of any and all applicable application fees.

_____ _____
Signature Date

Authorization to Obtain Information

If I am continuing to practice as an APRN, I authorize the MA Board of Registration in Nursing to obtain substantiating information from the organization _____ that certifies my advance practice for the purpose of verification. (Professional Organization Name)

_____ _____
Signature Date