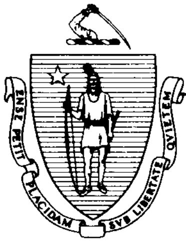

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Nursing
239 Causeway Street, Suite 500, 5th Floor, Boston, MA 02114
617-973-0900 617-973-0895 TTY
www.mass.gov/dph/boards/rn

Name: ____ Date:_________________

Address: ____

Last 4 digits of SSN: ___________ Date of Birth: __ / __ / __

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

Email address: ____
(must be legible)

Request to Change Advanced Practice Registered Nurse Authorization to "Expired"

Advanced Practice Registered Nurse (APRN) category to change to "Expired":

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

Reason for request:

I no longer intend to practice in this APRN category ☐ I am retired ☐
I am no longer certified in this APRN category ☐ 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 place my authorization to practice as an APRN in the Commonwealth of Massachusetts as "expired" in the Board's data base. Further, I understand that if, and when I wish to request my APRN authorization be "current" that I will be required to satisfy the renewal requirements for APRN practice in effect at the time of the request to make authorization "current".

____ _________________________
Licensee Signature Date