MINNESOTA BOARD OF NURSING

1210 Northland Drive #120, Mendota Heights, MN 55120
Voice: 612-317-3000 | Fax: 651-688-1841 |TTY: 800-627-3529
Toll Free (MN, IA, ND, SD, WI): 888-234-2690
Email: nursing.board@state.mn.us
Website: www.nursingboard.state.mn.us

CONFIRMATION OF PROGRAM COMPLETION FOR LICENSURE BY EXAMINATION

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements.

Until you are issued a license, all data submitted on the application, except your name and address, are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the application become public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

• Type or print clearly • Use black ink • Provide all information • Incomplete forms will be returned • Do not use initials or abbreviations

APPLICANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
E-MAIL ADDRESS	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female
COMPLETION DATE (mm/dd/yyyy)	NAME OF SCHOOL OF NURSING (no initials)	CITY, STATE/PROVINCE OF SCHOOL OF NURSING

AFFIDAVIT SECTION

↓ This Section for School Use Only - Applicant: Do Not Write Below This Line ↓

SCHOOL OFFICIAL: Complete Affidavit Section after the above named applicant has fulfilled all the requirements of the nursing program and is eligible for graduation.

Is approval of the nursing program required by the Board of Nursing? ☒ Yes ☐ No Name of the Board of Nursing granting program approval WI Board of Nursing	PROGRAM TYPE (check one) ☒ REGISTERED NURSE ☐ PRACTICAL/VOCATIONAL NURSE
NAME OF SCHOOL OF NURSING (Complete name of institution) Northwood Technical College (previously known as Wisconsin Indianhead Technical College)	COMPLETION DATE (mm/dd/yyyy):
STREET ADDRESS 1900 College Dr	
CITY: Rice Lake / STATE/PROVINCE: WI / ZIP/POSTAL CODE: 54868 / COUNTRY: USA	

The undersigned does hereby affirm that the information provided is true and correct.

_____
Signature of School Official

_____
Title (Dean, Program Director, or Institutional Registrar)

Affix **School** Seal or Stamp

SCHOOL OFFICIAL: Return completed form to Minnesota Board of Nursing. This form must be sent to the Board directly from the Nursing Program.