

## 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/POS		P/POSTAL	CODE	COUNTRY	
E-MAIL ADDRESS	l	BIRTH	BIRTH DATE (mm/dd/yyyy)		GENDER 🗌 Male 📄 Female		
COMPLETION DATE (mm/dd/yyyy)	NAME OF SCHOOL OF NURSING (no initials) CIT			CITY, ST	Y, STATE/PROVINCE OF SCHOOL OF NURSING		
05/13/2022				Rice L	ce Lake, WI		
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	_				OGRAM TYPE (check one)		
Name of the Board of Nursing grad				X REGISTERED NURSE PRACTICAL/VOCATIONAL NURSE			
NAME OF SCHOOL OF NURSING (C				COMPLETION DATE (mm/dd/yyyy):			
Northwood Technical College (fka				05/13/2022			
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							
Affix <b>School</b> Seal or Stamp							
Title (Dean, Program Director, or Institutional Registrar)							
SCHOOL OFFICIAL: Return completed form to Minnesota Board of Nursing. This form							
must be sent to the Board directly from the Nursing Program.							