



# 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

[www.mass.gov/dph/boards/rn](http://www.mass.gov/dph/boards/rn)

## Instructions and Information

### **APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE AUTHORIZATION**

**Important Note:** To practice as an Advanced Practice Registered Nurse (APRN) in Massachusetts (MA), you must hold a valid, current Registered Nurse (RN) license issued by the MA Board of Registration in Nursing (Board). Temporary licenses are not issued. An APRN may practice only in the clinical category of advanced practice for which the Board has authorized (see application for clinical categories). Applicants applying for reciprocity may submit RN application at the same time an APRN application is submitted.

#### **APRN Authorization Requirements**

**[M.G.L. c. 112, s. 80B & 244 CMR 4.00 & 9.04 (1), (2) and (4) & Licensure Policy 00-01]**

1. Good moral character, as established by M.G.L. c 112 s. 74 and Board Policy.
2. Current, valid Massachusetts licensure as a Registered Nurse (RN).
3. Graduation from an APRN education program accredited by a Board-recognized national accreditation body.
4. Current advanced practice certification by Board-approved nationally recognized certifying body.
5. Payment of all required fees.

**Carefully read the following information and instructions prior to completing the enclosed application.**

#### **Instructions for Completing APRN Authorization Application and Fees**

The Board has contracted with Professional Credential Services, Inc. (PCS), Nashville, TN, for the processing of applications, verifications, and fees. Once an application is submitted, all correspondence is by email to the address provided in your application. An application received without payment will be returned.

**Each application for initial, additional or reciprocal authorization must be received by PCS, fully completed and legible, with required documentation, before it will be reviewed.** The following documentation must be verified for each application for APRN authorization:

1. Applicant must have current Massachusetts RN license. APRNs seeking reciprocity must apply for and receive Massachusetts RN licensure in addition to applying for APRN authorization. Licensure applications are available at [www.pcshq.com](http://www.pcshq.com).
2. Verification of certification status sent by a Board approved APRN certification organization directly to PCS at **ATTN: MA Board of Registration in Nursing, C/O MA Nurse Coordinator, Professional Credential Services, P.O. Box 198788, Nashville, TN 37219** or by email to [aprn@pcshq.com](mailto:aprn@pcshq.com). The following APRN certifying organizations are accepted by the Board:
  - Nurse Anesthetists: National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA);
  - Nurse Midwives: American Midwifery Certification Board (AMCB);
  - Nurse Practitioners: American Academy of Nurse Practitioners (AANP), American Nurses Credentialing Center (ANCC), National Certification Corporation (NCC), Pediatric Nursing Certification Board (PNCB), American Association of Critical-Care Nurses (AACN);
  - Psychiatric Nurse Mental Health Clinical Specialists: American Nurses Credentialing Center (ANCC);
  - Clinical Nurse Specialists: American Nurses Credentialing Center (ANCC), American Association of Critical-Care Nurses (AACN).

3. Official transcript from the APRN nursing education program the applicant graduated from contained in a sealed envelope sent directly to PCS at **ATTN: MA Board of Registration in Nursing, C/O MA Nurse Coordinator, Professional Credential Services, P.O. Box 198788, Nashville, TN 37219.**
4. If the applicant is currently or has ever been licensed as a nurse (LPN and/or RN and/or APRN) in any state or jurisdiction, verification of licensure status must be completed. PCS will verify your Massachusetts nurse license; for all others you must complete the steps below.
  - For all states which participate in the Nursys License Verification System:
    - Go to [www.nursys.com](http://www.nursys.com) and follow the instructions including paying the necessary fee. Nursys will post your verification online and it will remain available for 90 days.
  - For all states which do not participate in the NURSUS License Verification System:
    - Complete the authorization portion at the top of page 5 of the attached *Verification of Nurse Licensure* (RN/LPN) form verification and/or page 6 of the attached *Verification of Advanced Practice Registered Nurse Authorization* (APRN) form;
    - Enclose the appropriate verification fee (*contact the Board of Nursing in that state for fee and instructions*); and
    - Submit the form directly to the Board of Nursing in that state (*that board will complete the form and must mail directly to PCS on your behalf*).
5. If you answer “yes” to any questions related to the good moral character licensure requirement, consult the Board’s [Licensure Policy 00-01: Determination of Good Moral Character Compliance](#) and the [Determination of Good Moral Character Compliance Information Sheet](#) at [www.mass.gov/dph/boards/rn](http://www.mass.gov/dph/boards/rn) **before** submitting application. The Board must determine your compliance with this requirement before authorizing APRN practice.
6. Submission of completed application and fee acknowledges that the applicant understands and agrees to all provisions herein
7. **Important note:** All fees are non-refundable and non-transferable. The application fee must be made by credit card or money order via the payment form found on page 4. Personal checks are not accepted.

**8. Retain copies of all information and completed application for future reference**

**VALOR Act**

Active military members and spouses of members of the armed forces of the United States may be eligible for certain provisions of the VALOR Act. For additional information, please go to:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/attention-active-military-military-spouses-and-veteran.html>.

**Social Security Number**

A United States Social Security Number (SSN) is required. Pursuant to M.G.L. c. 30A, s. 13A, the Massachusetts Board of Registration in Nursing is required to obtain your SSN on behalf of the Massachusetts Department of Revenue (DOR). The DOR will use your SSN to ascertain whether you are in compliance with Massachusetts laws relating to taxes and child support. If you do not have a SSN *and are eligible for one*, you must obtain one and provide it to the Board. In the absence of an SSN, this application will not be processed and the fees will not be refunded nor transferred. For complete SSN information, contact the U.S. Social Security Administration at: 800-772-1213, or [www.ssa.gov](http://www.ssa.gov).

**SUBMIT APPLICATION AND PAYMENT TO:**

**Professional Credential Services  
ATTN: MA Nurse Coordinator  
P. O. Box 198788  
Nashville, TN 37219**

**For confirmation of receipt by PCS, please use certified mail.**

**Inquiries should be directed to:**

**[aprn@pcshq.com](mailto:aprn@pcshq.com)**

**or toll free at 877-887-9727**

**or visit <http://www.pcshq.com>**


**Applications are reviewed only after *all* required documents and fees are received. Authorization is granted based on the applicant's compliance with the above eligibility requirements.**

- Your application is active for one year from the date it is received by PCS. All requirements must be completed and all documents must be received while your application is active. Submission of subsequent applications required for incomplete, inaccurate, altered or changed information remain active from the date the original application is received by PCS.
- **Applications with missing/incomplete/altered entries (including cross-outs, white-outs, or similar alterations) will not be accepted for review and require submission of a new application.** Each application is required to have a recent (within one year) 2 X 2 photo, signed on front bottom edge and stapled to application.
- Changes in identifying data such as address or name that occur between the time of application submission and receipt of authorization will require submission of a new application. Telephone calls are not accepted for changes
- **PCS has no control over timely submission of documentation.** Once PCS has received your completed application INCLUDING all required application related documents, please allow approximately three (3) business days for the review and authorization process
- If you are submitting this application within 90 days of the expiration date of your MA RN license, you may have to renew early in order to ensure that the time frame for expiration of your Massachusetts RN license exceeds 90 days. You can renew your RN license anytime within the 90 days prior to the expiration date on line at <http://onlineservices.hhs.state.ma.us/> or by requesting a paper application at [renew.bymail@state.ma.us](mailto:renew.bymail@state.ma.us).
- Should your school transcript not readily identify specific APRN clinical category preparation and/or advanced course requirements (health assessment, pathophysiology and pharmacotherapeutics), you may be requested to obtain additional information from your educational program
- PCS emails *Letter of Authorization* within one (1) week of approval and submits notification to the Board electronically, then MA Board posts authorization on its website within 3 business days
- You may **NOT** practice as an APRN until your authorization appears on the Board's website. It is the applicant's responsibility to confirm the authorization as current on the Board's website

**Complete Checklist prior to signing application.**

**Your signature attests that you have read and completed all application requirements.**

Contact PSC with any questions: 877-887-9727 Web site: <http://www.pcshq.com> E-mail: [nursebyexam@pcshq.com](mailto:nursebyexam@pcshq.com)

Check if Complete	Application Checklist	Additional Information
<input type="checkbox"/>	Completed application is legible. No missing information, cross outs or white outs	Use "N/A" if a question does not apply.
<input type="checkbox"/>	Correct APRN clinical category selected	Must match educational program and certification
<input type="checkbox"/>	MA RN license expiration date exceeds 90 days	If necessary, renew MA RN license to ensure expiration date exceeds 90 days
<input type="checkbox"/>	Nursys contacted for LPN, RN, APRN verification(s)	Fee must be included
<input type="checkbox"/>	Non-Nursys participating states contacted for LPN, RN, APRN verification(s)	Contact each Board for instructions and fees
<input type="checkbox"/>	Request transcript from APRN education program	Must be sent to PCS directly from educational program
<input type="checkbox"/>	Request verification of APRN certification	Must be sent to PCS directly from certifying organization
<input type="checkbox"/>	If you answer "yes" to any questions related to the good moral character licensure requirements 	Consult the Board's <a href="#">Licensure Policy 00-01: Determination of Good Moral Character Compliance</a> and follow directions contained in <a href="#">Determination of Good Moral Character Compliance Information Sheet</a> at <a href="http://www.mass.gov/dph/boards/rn">www.mass.gov/dph/boards/rn</a> <b>before</b> submitting application. The Board must determine your compliance with this requirement before authorizing APRN practice.



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## **APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE AUTHORIZATION**

**Clinical Category:** *(check only one)* ☐ **NURSE PRACTITIONER (CNP)** ☐ **NURSE ANESTHETIST (CRNA)**  
☐ **NURSE MIDWIFE (CNM)** ☐ **PSYCHIATRIC CLINICAL NURSE SPECIALIST (PCNS)**  
☐ **CLINICAL NURSE SPECIALIST (CNS)**

**TYPE OR PRINT USING BLACK INK**

**U.S. SOCIAL SECURITY NUMBER (SSN):** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Mandatory pursuant to G.L. c. 30A, s. 13A; see instructions.

**NAME:** \_\_\_\_\_  
(First) (Middle) (Last) (Maiden /Previous)

**E-MAIL ADDRESS:** \_\_\_\_\_ **TELEPHONE NUMBER:** \_\_\_\_\_  
(Email will be primary method of communication during application review)

**ADDRESS OF RECORD:**  
(Mailing address) \_\_\_\_\_  
(No.) (Street) (Apt/Suite/Floor)  
(City) (State or Country) (Zip/Postal Code)

**ADVANCED PRACTICE NURSING EDUCATION PROGRAM NAME AND LOCATION:** \_\_\_\_\_

**DATES OF PROGRAM ATTENDANCE (mo/yr):** \_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_ ☐ **CERTIFICATE** ☐ **MASTERS** ☐ **DOCTORATE**

**NAME OF NATIONAL CERTIFYING BODY:** \_\_\_\_\_

**CERTIFICATION NUMBER:** \_\_\_\_\_ **DATE GRANTED:** \_\_\_\_\_ **EXPIRATION DATE:** \_\_\_\_\_

**Do you currently hold or have you previously held RN licensure in Massachusetts?** ☐ **No** ☐ **Yes**

The Board cannot issue you a valid APRN authorization if your current Massachusetts (MA) RN license is due to expire within 90 days of authorization approval. If you are submitting this application within 90 days of the expiration date of your MA RN license, you may have to renew early in order to ensure that the time frame for expiration of your MA RN license exceeds 90 days.

**Do you currently hold or have you previously held authorization to practice as an APRN in Massachusetts?** ☐ **No** ☐ **Yes** **If YES, indicate the Clinical Category:**

☐ **CNP** ☐ **CRNA** ☐ **PCNS** ☐ **CNM** ☐ **CNS**

If you are currently or have ever been licensed as a nurse (LPN and/or RN and/or APRN) in the United States, District of Columbia, U.S. territories, or in another country after licensure in the U.S. or its territories, verification of each licensure status must be completed. PCS will verify your Massachusetts nurse license only.

• **For all states that participate in the Nursys License Verification System:**

Go to [www.nursys.com](http://www.nursys.com) and follow the instructions including paying the necessary fee.

• **For all states that do not participate in the NURSYS License Verification System:**

Complete the authorization portion at the top of page 5 of the attached *Verification of Nurse Licensure* (RN/LPN) form verification and/or page 6 of the attached *Verification of Advanced Practice Registered Nurse Authorization* (APRN) form; Enclose the appropriate verification fee (*contact the Board of Nursing in that state for fee and instructions*); Submit the form directly to the Board of Nursing in that state (*that board will complete the form and must mail directly to PCS on your behalf*).

**Provide the following information regarding any Practical/Vocational Nurse, any Registered Nurse license or any APRN license or authorization you currently or previously held (include MA):**

	STATE, TERRITORY, COUNTRY	LICENSE TYPE or APRN CLINICAL CATEGORY	LICENSE NUMBER	STATUS
Initial RN license				

**If necessary, continue on another sheet of paper. Please be sure not to omit any states or licenses. Omissions will delay the processing of your application.**

If you answer “yes” to any of the following questions, the Board must evaluate your compliance with the Good Moral Character licensure requirement. This evaluation must be completed to determine your qualifications for initial APRN authorization in Massachusetts. Prior to submitting this application, review the Board’s [Licensure Policy 00-01: Determination of Good Moral Character Compliance](#) and the [Determination of Good Moral Character Compliance Information Sheet](#). Submit all required documentation to the Board as directed.

	<b>Answer all questions truthfully and accurately.</b>	YES	NO
1.	Has any disciplinary action ever been taken against you by a professional and/or trade licensing/certification board located in the United States, the District of Columbia, U.S. territory, or any country/foreign jurisdiction, including removal from a long-term care nurse aide registry program?		
2.	Are you the subject of pending disciplinary action by a professional and/or trade licensing/certification board located in the United States, the District of Columbia, U.S. territory, or any country/foreign jurisdiction?		
3.	Have you ever applied for, and been denied, a professional and/or trade license/certification in the United States, the District of Columbia, U.S. territory, or any other country/foreign jurisdiction?		
4.	Have you ever surrendered or resigned a professional and/or trade license/certificate in the United States, the District of Columbia, U.S. territory, or any other country/foreign jurisdiction?		
5.	Have you ever been convicted of a felony or misdemeanor in the United States, the District of Columbia, U.S. territory, or any other country/foreign jurisdiction?		
6.	Are you the subject of any pending or open criminal case (s) or investigation(s), (including for any felony or misdemeanor) in a jurisdiction in the United States, the District of Columbia, U.S. territory, or any country/foreign jurisdiction?		



**If you have answered “yes” to any of the above questions, the Board may deny your application for licensure. Denial of licensure by the Board is considered a disciplinary action and may have consequences before other professional licensing and certifying boards, including any licenses or certifications you may currently hold.**



**If you answered “yes” to question #6, DO NOT submit this application. In accordance with Licensure Policy 00-01: *Determination of Good Moral Character Compliance* the Board will deny licensure if the applicant has failed to fulfill all requirements imposed by a licensure or certification body or if all criminal matters have not been closed for at least one (1) year.**



**ATTESTATION:** By signing this application for APRN authorization, I certify, under the pains and penalties of perjury, that:

- The information that I have provided in connection with this application is truthful and accurate;
- I understand that the failure to provide truthful and accurate information may be grounds for the Massachusetts Board of Registration in Nursing (Board) to deny my nurse licensure in accordance with Massachusetts law and may effect my ability to obtain licensure/authorization and/or practice nursing in this or any other jurisdiction in which I am currently licensed or may seek licensure in the future;
- I have read and understand the Board's Licensure Policy 00-01: *Determination of Good Moral Character Compliance* and the *Determination of Good Moral Character Compliance Information Sheet*;
- I understand that an application is active for one year. Submission of subsequent applications required for incomplete, inaccurate, altered or changed information will be active from the date the original application is received by PCS. All requirements must be completed and all documents must be received while your application is active;
- I understand that fees are non-refundable and non-transferable;
- I understand participation in MassHealth for the limited purposes of ordering and referring services covered under such program is required as an APRN practice condition. [Ref: MGL c. 112, § 80B] For details and forms, visit <http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html>;
- I understand that I must complete education prior to registering with the MA Department of Public Health Drug Control Program (DCP) as a prescriber and subsequently, during each licensure renewal period consistent with MGL c. 94C, § 18(e). For details, visit: <http://www.mass.gov/eohhs/gov/departments/dph/programs/hcg/dhpl/nursing/pmp-alert.html>;
- If I am granted APRN authorization by the Board, I will comply with M.G.L. c. 112, §§ 74 through 81C as well as any other laws and regulations (including those at 244 CMR 3.00 through 9.00 related to licensure and practice);
- Submission of completed application and fee acknowledges that the applicant understands and agrees to all provisions herein;
- I have completed the checklist in the application instructions.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Mail to:

**Professional Credential Services, Inc.  
ATTN: MA Nurse Coordinator  
P. O. Box 198788  
Nashville, TN 37219**

STAPLE  
A RECENT 2X2  
PASSPORT TYPE  
COLOR PHOTO  
HERE.

FACE ONLY.

**SIGN FRONT  
BOTTOM EDGE OF  
PHOTO.**



P.O. Box 198788  
Nashville, TN 37219

**APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE (APRN) AUTHORIZATION**

**Payment Form**

Two payment options are available: Money Order or Credit Card.

Applicant Name: \_\_\_\_\_

Social Security Number (Mandatory): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Fees are non-refundable and non-transferable.**

**Advanced Practice Authorization Application Fee: \$150.00**

*Please check form of payment below:*

- ☐ Money Order (*Please ensure the applicant's name is on the payment*)  
If paying by Money Order, please make it payable to "PCS."

***Or***

- ☐ Credit Card

Authorized payment amount: \$ \_\_\_\_\_ Please check one: ☐ Visa ☐ MasterCard

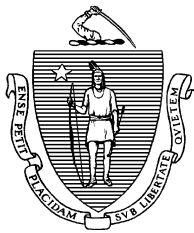
Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp: \_\_\_\_ / \_\_\_\_

Print name as it appears on account: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Return this payment form with Application Form. DO NOT staple your payment to this form.

Note: This document will be shredded after it has been processed.



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## VERIFICATION OF LICENSED PRACTICAL AND/OR REGISTERED NURSE LICENSURE

### APPLICANT: COMPLETE THIS SECTION ONLY

I, \_\_\_\_\_, ☐ RN ☐ LPN/LVN License Number \_\_\_\_\_, am applying to the Massachusetts Board of Nursing for licensure by reciprocity. I hereby authorize you to furnish to the Massachusetts Board of Nursing the information requested below.

This is the original state of issue? Yes ☐ No ☐

(Date)

(Signature)

(Maiden Name)

APPLICANT: DO NOT WRITE BELOW THIS LINE

Applicant Name as Appearing on Original License \_\_\_\_\_

Applicant Name as Appearing on Current License \_\_\_\_\_

### NURSING EDUCATION

PROGRAM NAME AND LOCATION: \_\_\_\_\_

Board Approved: Yes ☐ No ☐

Language of Nursing Instruction: \_\_\_\_\_ Classroom Instruction \_\_\_\_\_ Course Textbooks \_\_\_\_\_ Clinical Practice \_\_\_\_\_

Program: ☐ Practical Nurse/Vocational Nurse ☐ Registered Nurse ☐ Withdrawn from RN program

Type: ☐ Certificate ☐ Diploma Degree: ☐ Associate ☐ Baccalaureate ☐ Entry Level Masters

Month/Year Graduated (or withdrawn, if applicable) \_\_\_\_\_ Length of Program \_\_\_\_\_

Applicant Registration Number \_\_\_\_\_ Date of Original Issue \_\_\_\_\_

Current Licensure Status: \_\_\_\_\_ Expiration Date \_\_\_\_\_

Method of Licensure (Check One): Examination ☐ Waiver ☐ Reciprocity ☐

Type of Exam: NCLEX ☐ SBTPE ☐ Exam Date \_\_\_\_\_

Has License Ever Been Disciplined? Yes ☐ No ☐ (If "Yes", Provide A Certified Copy of All Related Documents.)

Is Applicant Currently Under Investigation? Yes ☐ No ☐ (If "Yes" Please Explain.)

I certify the above to be a true report for the above-named Nurse according to the records in this office.

Authorized Person Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_ Jurisdiction: \_\_\_\_\_

Affix Board Seal

Mail to:

Professional Credential Services  
ATTN: MA Nurse Coordinator  
P.O. Box 198788  
Nashville, TN 3721





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## VERIFICATION OF ADVANCED PRACTICE REGISTERED NURSE AUTHORIZATION

### APPLICANT: COMPLETE THIS SECTION ONLY

I, \_\_\_\_\_, ☐ CNP ☐ CNM ☐ CRNA ☐ PCNS ☐ CNS  
License Number \_\_\_\_\_, am applying to the Massachusetts Board of Nursing for Advanced Practice authorization by reciprocity. I hereby authorize you to furnish to the Massachusetts Board of Nursing the information requested below.

(Date)

(Signature)

(Maiden Name)

**APPLICANT: DO NOT WRITE BELOW THIS LINE**

Applicant Name as Appearing on Original License \_\_\_\_\_

Applicant Name as Appearing on Current License \_\_\_\_\_

Advance Practice Program \_\_\_\_\_ Year Graduated \_\_\_\_\_

Location \_\_\_\_\_ Board Approved: Yes ☐ No ☐

Type of Program \_\_\_\_\_ Length of Program \_\_\_\_\_

APRN Registration Number \_\_\_\_\_ Date of Original Issue \_\_\_\_\_

Current Licensure Status: \_\_\_\_\_ Expiration Date \_\_\_\_\_

Method of Authorization: (Check One) Original ☐ Waiver ☐ Reciprocity ☐

National Certification by: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Has License Ever Been Disciplined? Yes ☐ No ☐ (If "Yes", Provide A Certified Copy of All Related Documents.)

Is Applicant Currently Under Investigation? Yes ☐ No ☐ (If "Yes" Please Explain.)

I certify the above to be a true report for the above-named Nurse according to the records in this office.

Authorized Person Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_ Jurisdiction: \_\_\_\_\_

Affix Board Seal

Mail to:

Professional Credential Services  
ATTN: MA Nurse Coordinator  
P.O. Box 198788  
Nashville, TN 37219