New Mexico Board of Nursing
6301 Indian School Rd NE, Suite 710
Albuquerque, NM 87110

Tel: (505) 841-8340

VERIFICATION OF ADVANCED PRACTICE REGISTERED NURSE LICENSURE FORM

Must be received directly from the Nursing Regulatory Body

PART I: TO BE COMPLETED BY THE APPLICANT AND FORWARDED TO ORIGINAL STATE OF LICENSURE WITH THEIR FEE.

Name:_____
Last First Middle Maiden

Mailing Address: _____
Number Street Apartment City State Zip

Birth Date:_____ Social Security Number:_____

APRN type (*select appropriate box*):
☐Certified Nurse Practitioner ☐Certified Registered Nurse Anesthetist ☐Clinical Nurse Specialist

State of original licensure_____ License number:_____

APRN Education Program: Name of Institution:_____

Location of Program:_____ Date of completion_____

Degree granted_____ or Certificate granted_____

I authorize_____ to release my APRN licensure information to the New Mexico Board of Nursing.
Applicant's Signature:_____ Date:_____

PART II: TO BE COMPLETED BY THE LICENSING BOARD OF ORIGINAL STATE OF LICENSURE.

APRN TYPE (*SELECT APPROPRIATE BOX*): ☐CERTIFIED NURSE PRACTITIONER ☐CERTIFIED REGISTERED NURSE ANESTHETIST ☐CLINICAL NURSE SPECIALIST

This is to certify that_____(Please select one)

_____ licensed as an APRN. Initially licensed as an APRN _____
Date

_____ licensed as an APRN (state does not specify practice area). Initially licensed as an APRN _____
Date

_____ State does not issue license for APRN. (Please explain how advanced practice is recognized in state)_____

Signature_____

Title_____

State_____

Date_____

STATE SEAL