



STATE OF MISSOURI  
 DIVISION OF PROFESSIONAL REGISTRATION  
**CONSENT TO RELEASE CERTIFICATION INFORMATION**  
 PLEASE SEND THIS FORM TO YOUR CERTIFYING BODY.  
 CHECK WITH CERTIFYING BODY TO DETERMINE APPLICABLE FEES.

BOARD OF NURSING  
 P.O. BOX 656  
 JEFFERSON CITY, MO 65102-0656  
 TELEPHONE (573) 751-0681  
 TEXT TELEPHONE (TTY)  
 1-800-735-2966  
 HEARING IMPAIRED  
<http://pr.mo.gov>

NAME OF LICENSEE (PRINT)		MISSOURI RN LICENSE NUMBER	
CURRENT ADDRESS OF LICENSEE			
CERTIFICATION NUMBER (IF APPLICABLE)		EXPIRATION DATE	
TYPE OF CERTIFICATION <input type="checkbox"/> NURSE ANESTHETIST <input type="checkbox"/> NURSE MIDWIFE <input type="checkbox"/> NURSE PRACTITIONER <input type="checkbox"/> CLINICAL NURSE SPECIALIST			
NAME OF CERTIFYING BODY			
I authorize the above named certifying body to disclose information regarding the identification, evaluation, and certification of the above named licensee that is maintained by the above named certifying body to the Missouri State Board of Nursing, its representatives and the Administrative Hearing Commission or court. I authorize the Missouri State Board of Nursing to utilize this information as needed for validation, investigation, litigation, discipline, or agreements concerning my nursing license. This authorization to release the above requested information shall expire at my written request. A copy of this request shall be as effective as the original.			
SOCIAL SECURITY NUMBER (VOLUNTARY, USED FOR IDENTIFICATION PURPOSES ONLY)			
SIGNATURE OF LICENSEE		DATE	
SIGNATURE OF WITNESS		DATE	
<b>INFORMATION REQUESTED BELOW TO BE COMPLETED BY CERTIFYING BODY</b>			
NAME OF PERSON CERTIFIED		INITIAL DATE OF CERTIFICATION	
CERTIFICATION NUMBER (IF APPLICABLE)		EXPIRATION DATE OF CURRENT CERTIFICATION/MAINTENANCE CYCLE	
Type of Certification: <input type="checkbox"/> Nurse Anesthetist <input type="checkbox"/> Nurse Midwife <input type="checkbox"/> Nurse Practitioner - specify specialty area _____ <input type="checkbox"/> Clinical Nurse Specialist - specify specialty area _____			
1. Is certification current?		<input type="checkbox"/> Yes	<input type="checkbox"/> No**
2. Has certification lapsed?		<input type="checkbox"/> Yes**	<input type="checkbox"/> No
3. Has certification been revoked?		<input type="checkbox"/> Yes**	<input type="checkbox"/> No
4. Is certification provisional or conditional in any manner?		<input type="checkbox"/> Yes**	<input type="checkbox"/> No
5. Is actively and satisfactorily participating in meeting recertification/maintenance terms and/or continuing education/competency requirements?		<input type="checkbox"/> Yes	<input type="checkbox"/> No**
Please explain 'no' response to number 1 and number 5 and 'yes' responses to numbers 2, 3 or 4:			
_____			
_____			
NAME OF CERTIFYING BODY			
NAME OF PERSON COMPLETING INFORMATION REQUESTED		TITLE	DATE