



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
**GRADUATE NURSE AUTHORIZATION TO  
 RELEASE CONFIDENTIAL INFORMATION –  
 FOR NURSING PROGRAM**

**MAILING ADDRESS:**  
 STATE BOARD OF NURSING  
 PO BOX 656  
 JEFFERSON CITY, MO 65102-0656  
 (573) 751-0681  
 Email: [nursing@pr.mo.gov](mailto:nursing@pr.mo.gov)  
 Website: <http://pr.mo.gov/nursing.asp>

**DELIVERY ADDRESS:**  
 3605 MISSOURI  
 BOULEVARD  
 JEFFERSON CITY, MO 65109

**INSTRUCTIONS**

Please complete the form below.

**PERSONAL INFORMATION**

GRADUATE NURSE FIRST AND LAST NAME

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER

**NURSING PROGRAM INFORMATION**

NURSING PROGRAM ATTENDED

NCLEX PROGRAM CODE

**AFFIRMATION**

I, \_\_\_\_\_, hereby authorize the **MISSOURI STATE BOARD OF NURSING** to release any and all information regarding my licensure and exam application status as a Licensed Practical Nurse/Registered Professional Nurse to \_\_\_\_\_ and/or their representatives.

This release authorizes the Missouri State Board of Nursing to release my name, address, nursing school name, graduation date, eligibility status, test appointment date, date exam was taken, whether or not I took the exam, examination results, and my NCLEX Candidate Performance Report.

A photo static copy of this authorization will be considered as effective and valid as the original.

SIGNATURE

DATE

GRADUATE NURSE'S EMAIL ADDRESS

@

NURSING PROGRAM EMAIL ADDRESS

@

**PLEASE SUBMIT THIS FORM WITH THE MISSOURI STATE BOARD OF NURSING APPLICATION FOR LICENSURE.**