



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

MAILING ADDRESS:
 STATE BOARD OF NURSING
 PO BOX 656
 JEFFERSON CITY, MO 65102-0656
 (573) 751-0681
 Email: 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

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, and examination results.

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

SIGNATURE

DATE

NURSE'S EMAIL ADDRESS

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EMPLOYERS EMAIL ADDRESS

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