

**MISSOURI STATE BOARD OF NURSING  
CONTINUED RECOGNITION REPORT FORM  
(For Noncertified Recognition Only)**

**PRINT the following information:**

Name: \_\_\_\_\_ MO License Number: RN \_\_\_\_\_

Address \_\_\_\_\_  
(Street, Box, or Route)

\_\_\_\_\_ Telephone No. \_\_\_\_\_  
City State Zip Daytime

\_\_\_\_\_ Recognition Expiration Date

**Please list the clinical practice hours and contact hours\* for the current two (2) year reporting period on the reverse side of this form. Your current reporting period ends on the recognition expiration date identified on your Document of Recognition and began exactly two (2) years prior to this expiration date.**

**\*CONTACT HOUR KEY:**

**ONE (1) CEU = TEN (10) CONTACT HOURS**

**ONE (1) CONTACT HOUR = FIFTY (50) MINUTES OF CLOCK HOUR**

**ONE (1) ACADEMIC CREDIT = FIFTEEN (15) CONTACT HOURS**

**ONE (1) CME = SIXTY (60) MINUTES = 1.2 CONTACT HOURS**

**\*For further contact hour clarification see rule, 20 CSR 2200-4.100 Advanced Practice Nurse, (1)(A) and (8)(D)2.**

**Attach copies of actual records supporting completion of clinical practice hours and contact hours for the current reporting period that ends on your recognition expiration date. Licensees are also advised to maintain their own copies of such records for preceding reporting periods and the current reporting period.**

**Return this completed form and all supporting documents to the following address at least 30 days prior to the recognition expiration date:**

Missouri State Board of Nursing  
P.O. Box 656  
Jefferson City, MO 65102

**For questions, please call the Board office:**

(573) 751-0073 or e-mail your questions to [nursingpractice@pr.mo.gov](mailto:nursingpractice@pr.mo.gov)

Revised 5/27/1999  
10/21/1999  
10/26/2006

**MISSOURI STATE BOARD OF NURSING**  
**Continued Recognition Report Form\***  
**(For Noncertified Recognition Only)**

Name (print): \_\_\_\_\_

Recognition Reporting Period: From \_\_\_\_\_ through \_\_\_\_\_. Total Clinical Practice Hours for Period: \_\_\_\_\_.  
(m/d/y) (m/d/y) Total Contact Hours for Period: \_\_\_\_\_.

**CLINICAL PRACTICE HOURS** (A minimum of 800 hours of clinical practice in the recognized advanced practice nursing clinical specialty area must be earned within every two years following recognition):

FROM (m/d/y)	TO (m/d/y)	NAME OF CLINICAL SETTING (include address, telephone #)	PROFESSIONAL CONTACT IN SETTING	RECOGNIZED SPECIALTY AREA ROLE/RESPONSIBILITIES	TOTAL NUMBER OF CLINICAL PRACTICE HOURS

**CONTACT HOURS** (A minimum of 60 contact hours in the recognized advanced practice nursing clinical specialty area offered by an accredited college/university must be earned within every two years following recognition):

FROM (m/d/y)	TO (m/d/y)	NUMBER OF EARNED CONTACT HOURS	SPONSOR	COURSE TITLE	PRESENTER/S	LOCATION

By my signature, I hereby swear or affirm that the above information is complete and accurate evidence of my advanced practice nursing clinical practice and continuing education in my recognized clinical nursing specialty area.

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

\* make additional copies of this page if more space is needed