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

Revised 5/2719/99
10/21/1999
10/26/2006
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):

<table>
<thead>
<tr>
<th>FROM (m/d/y)</th>
<th>TO (m/d/y)</th>
<th>NAME OF CLINICAL SETTING (include address, telephone #)</th>
<th>PROFESSIONAL CONTACT IN SETTING</th>
<th>RECOGNIZED SPECIALTY AREA ROLE/RESPONSIBILITIES</th>
<th>TOTAL NUMBER OF CLINICAL PRACTICE HOURS</th>
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**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):

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<tr>
<th>FROM (m/d/y)</th>
<th>TO (m/d/y)</th>
<th>NUMBER OF EARNED CONTACT HOURS</th>
<th>SPONSOR</th>
<th>COURSE TITLE</th>
<th>PRESENTER/S</th>
<th>LOCATION</th>
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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 10/98