



## Affidavit of Practice as a Nurse in Minnesota

You are required to complete and return this ORHPC Affidavit of Practice to provide necessary documentation of your service as a licensed practical nurse or registered nurse in a nursing home or intermediate care facility for persons with developmental disabilities.

Participant Name: _____	Phone: (____) _____
Address: _____	Cell: (____) _____
City: _____	State: _____ Zip: _____
County: _____	E-Mail: _____
_____	MN License Number: _____
<b>Signature of Participant</b>	

Practice Site: _____	Phone: (____) _____
Address: _____	
City: _____	State: _____ Zip: _____
County: _____	

### To Be Completed by an Authorized Individual at the Practice Site Named Above

I certify that the above named nurse has worked full time (at least 30 hours per week) for at least 45 weeks per year at the nursing home or ICF/MR named above from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.  
**Date** **Date**

\_\_\_\_\_  
**Printed Name of Authorized Representative**

\_\_\_\_\_  
**Title of Authorized Representative**

\_\_\_\_\_  
**Signature of Authorized Representative**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Please return to:** Minnesota Department of Health, Office of Rural Health and Primary Care  
Attn: Loan Forgiveness Program Officer  
P.O. Box 64882 St. Paul, MN 55164-0882

**Or by Email:** [mohamed.samaha@state.mn.us](mailto:mohamed.samaha@state.mn.us) **Or by Fax** (651) 201-3830

For Questions, please contact Mohamed Samaha at (651) 201-3870 or (800) 366-5424.