FLORIDA BOARD OF NURSING

http://www.doh.state.fl.us/mqa/nursing

LICENSURE APPLICATION & INSTRUCTIONS

Application for Dual Registered Nurse (RN) and Advanced Registered Nurse Practitioner (ARNP)

October 2011

Regarding Prior Criminal History and Disciplinary Actions

The Florida Board of Nursing receives numerous questions from applicants regarding prior criminal offenses. Following are the most frequently asked questions to assist applicants.

Question: What crimes or license discipline must be reported on the application?

Answer: All convictions, guilty pleas and nolo contendere pleas must be reported, except for minor traffic violations not related to the use of drugs or alcohol. This includes misdemeanors, felonies, "driving while intoxicated (DWI)" and "driving under the influence "(DUI)." Crimes must be reported even if they are a suspended imposition of sentence. All prior or current disciplinary action against another professional license must be reported, whether it occurred in Florida or in another state or territory.

Question: Can a person obtain a license as a nurse if they have a misdemeanor or felony crime on their record?

Answer: Each application is evaluated on a case-by-case basis. The Board of Nursing considers the nature, severity, and recency of offenses, as well as rehabilitation and other factors. The Board cannot make a determination for approval or denial of licensure without evaluating the entire application and supporting documentation.

Question: Do I have to report charges if I completed a period of probation and the charges were dismissed or closed?

Answer: Yes. Offenses must be reported to the Board even if you received a suspended imposition of sentence and the record is now considered closed.

Question: What types of documentation do I need to submit in support of my application if I have a prior criminal record or license discipline?

Answer:

- Official court document(s) relative to your criminal record, showing the date(s) and circumstance(s) surrounding your arrest(s)/conviction(s), sections of the law violated, and disposition of the case. This would normally consist of the Complaint or Indictment, the Judgment, Docket Sheet or other documents showing disposition of your case. This can also be referred to as the Order of Probation. The court clerk must certify these court documents.

- Copy of the documents relative to any disciplinary action taken against any license. The documents must come from the agency that took the disciplinary action and must be certified by that agency.

- A detailed description of the circumstances surrounding your criminal record or disciplinary action and a thorough description of the rehabilitative changes in your lifestyle since the time of the offence or disciplinary action which would enable you to avoid future occurrences. It would be helpful to include factors in your life, which you feel, may have contributed to your crime or disciplinary action, what you have learned about yourself since that time, and the changes you have made that support your rehabilitation.

Note: The burden of proof lies with the applicant to demonstrate evidence of rehabilitation. Examples of rehabilitation evidence include, but are not limited to:

- If applicable to your crime or discipline, documented evidence of professional treatment and counseling you may have completed. Please provide a discharge summary, if available.
- Letters of reference on official letterhead from employers, nursing program administrator, nursing instructors, health professionals, professional counselors, support group sponsors, parole or probation officers, or other individuals in positions of authority who are knowledgeable about your rehabilitation efforts.
- Proof of community work, education, and/or self-improvement efforts.
- Court-issued certificate of rehabilitation or evidence of expungement, proof of compliance with criminal probation or parole, and orders of the court.

Question: How can I help facilitate how quickly my application is reviewed?
Answer: **The Board of Nursing strongly encourages all individuals with a criminal or discipline history to be fully prepared with information regarding their background and to start the application process early.**

<u>Applications with previous arrest or disciplinary action on a license will not be authorized to practice nursing until all documentation is cleared by Board staff or reviewed by the Board.</u>

GENERAL INFORMATION

Eligibility Requirements for Advanced Registered Nurse Practitioners

* This application cannot be used to apply for Clinical Nurse Specialist (CNS). Refer to www.doh.state.fl.us/mqa/nursing/nur_CNS_info.html for information on CNS.

For ARNP licensure requirements, refer to sections 464.008 and 464.009, Florida Statutes (F.S.), and Rules 64B9-3.002 & 3.008, Florida Administrative Code (F.A.C.).

REQUIREMENTS

1. **Master's Degree Requirement**
   Nurse practitioners who graduated on or after October 1, 1998 must have completed requirements for a master's degree or post-master's certification. Certified Registered Nurse Anesthetists who on or after October 1, 2001 must have completed requirements for a master's degree program. Applicants who graduated prior to the applicable date are exempt from this requirement.

   Graduates from either certificate or currently closed programs should submit supporting documentation that demonstrates program compliance with Board guidelines. This includes (a) copy of the philosophy and purpose of the program, (b) course objectives and content (syllabus, catalog, or brochures), and (c) faculty credentials including nurse practitioners on staff.

2. **National Certification Requirement**
   Applicants are required to submit proof of national advanced practice certification from an approved nursing specialty board (please see 3a below for acceptable format).

   After July 1, 2006, applicants for certification as an advanced registered nurse practitioner pursuant to Section 464.012(1) F.S. shall submit proof of national advanced practice certification from an approved specialty board.

   Applicant shall submit proof of national advanced practice certification from an approved nursing specialty board. After July 1, 2006, applications for certification as an Advanced Registered Nurse Practitioner pursuant to Section 464.012(1), F.S., shall submit proof of national advanced practice certification from an approved nursing specialty board.

   Rule 64B9-4.002(3), F.A.C., provides the professional or national nursing specialty boards recognized by the Board. You can find the full rule on the web at https://www.flrules.org/gateway/Organization.asp?OrgNo=64B9.

3. **Applicants currently nationally certified** must submit the following:

   a. Verification sent directly from the national certifying body or a copy of current certification (or recertification) card notarized as a “true and correct copy”. Test results are not considered proof of national certification.

   b. Evidence of malpractice insurance or exemption. Please see the Financial Responsibility Form in the supplemental documents section of the application. This form is the only acceptable format for proving malpractice or exemption.

4. **Provisional Licensure**

IMPORTANT: Nurse Anesthetists and Nurse Midwives are the only two specialties that qualify for the provisional license. *When the required documentation has been received and reviewed for completeness you may receive a one year provisional license allowing you to practice as a Nurse Anesthetist (NA) or Nurse Midwife (NM)* Your full ARNP license will be issued upon receipt of proof of national certification. Your provisional certification will become null and void one year from the date of issuance. If you do not pass the certification examination and provide proof of national certification within the provisional period, your license will revert to Registered Nurse (RN) only.

To qualify for provisional licensure requires the following:

- That you have graduated within the last 12 months prior to your application receipt
- That you are applying as a Nurse Anesthetist or Nurse Midwife
- That your transcripts and Verification of Successful Completion form are submitted directly to the Board office from your educational institution.

Application Checklist

FEES: **$318.00 for both initial RN/ARNP licensure OR**
$143.00 for ARNP only (If you already hold a valid FL RN license)

Please make cashier checks or money orders payable to the Florida Department of Health. Withdrawal of the application prior to completion entitles an applicants applying for both RN/ARNP licensure to a refund of $85.00 (initial licensure, student loan forgiveness and unlicensed activity fees). Applicants applying for only an ARNP license are not entitled to a refund.

- **Keep a copy of the completed application for your records.**
- **Please read all application instructions** and the Florida laws and rules governing the practice of nursing, before completing your application; you may obtain the laws and rules through the Board website www.doh.state.fl.us/mqa/nursing. You will be notified in writing of the status of your application within 30 days of receipt.
- **No application is complete until all required documentation and fees are received.** An incomplete application will delay final approval of that application. All documents become a permanent part of your file and cannot be returned. Applications are reviewed in date order received. Every question on the application must be answered honestly and completely. The Board of Nursing may deny your application if you provide false information.
- **The Board office must be notified in writing of anything that changes or affects a response given in your application.** Failure to do so could result in the delay of application processing, denial of your application or revocation of licensure. Examples: change of name, address, telephone number, arrests or convictions, licensure status or disciplinary action in another state, or an incorrect answer to a question.
- **Renewal of RN license prior to ARNP application.** The ARNP certification is an upgrade of your current Florida Registered Nursing License. Therefore, if your Florida RN license is up for renewal within 120 days of applying for ARNP certification, you must renew your Florida RN license before the ARNP license can be issued. Do not submit your renewal fee for your RN license as part of this application. You can renew your license online at http://www.flhealthsource.com.

(Section 1)

__________ **PERSONAL INFORMATION**: Refer to important note above section 1 on the application. Applications will be processed in the complete name provided in this section. Be sure to use the same name and address on all documentation.

Physical Location: Section 456.0.35, F.S. requires that all licensees have a Physical Address/Practice Location on file with the Florida licensure Board. In this section you must list your Physical location or the address where you intend to work. **If your mailing address is a P.O. Box you must provide another address. The Physical address will be listed on the Department of Health website. A Florida address is not required. We are unable to issue a license without this address.**

Name Change Documentation: To request a name change, you must submit proper documentation. Acceptable forms of proper documentation are a copy of a marriage license; divorce decree that indicates the restoration of your maiden name; a court order; driver's license or a U.S. Social Security card.

__________ **AVAILABILITY FOR DISASTER**: Please check YES or NO.

__________ **EQUAL OPPORTUNITY DATA**: Please complete the equal opportunity data.

(Section 2) **SPECIALTY TYPE**: Indicate the specialty type in which you are nationally certified or are currently seeking national certification.

(Section 3) **LICENSURE HISTORY**: List the year you began practicing as an Advanced Registered Nurse Practitioner. If this will be your first Advanced Registered Nurse Practitioner license and you have not began to practice indicate this by placing N/A on this line. If you currently hold a Florida Registered Nurse license indicate your license number in this section. If you are currently nationally certified list the national body you are certified through and your original certification date.

(Section 4)

__________ **APPLICANT BACKGROUND**: All items must be completed in full. On item 3 A and B list all names by which you have been known. In section C you must list all current and previous professional licenses. If you answer "Yes" to question E in this section you must submit a self explanation as to why you are answering "Yes" to this question.

(Section 5)

__________ **MANDATORY CONTINUING EDUCATION REQUIREMENT**: If you have completed a 2 hour course in Prevention of Medical Errors please attest to this by placing a check in the box in this section.

If you have not completed a 2 hour course in the Prevention of Medical Errors a license cannot be issued until proof of completion has been submitted. You may search for courses to satisfy this requirement through CE Broker at www.cebroker.com. CE courses are subject to audit. Licensees are required to maintain certificates for a period 4 years. Certificates should not be sent to the Board Office unless requested. Requirements for continuing education required for renewal can be found on the web at http://www.doh.state.fl.us/mqa/nursing/nur_ceu.html.

(Section 6)

__________ **NURSING EDUCATION HISTORY**: List the program name, address, degree or certification earned and the graduation date(s) of all nursing education.

Section 7)

_________ **FACULTY APPOINTMENTS**: In part A, list any nursing faculty appointments including title of appointment, institution, and city/state, include any preceptor roles. In part B, list any responsibility you have had for graduate education within the last 10 years.

(Section 8)

_________ **LIABILITY CLAIMS**: Answer the question in this section. A "Yes" answer requires additional information. See this section of the application for specific requirements.

(Section 9)

_________ **CRIMINAL HISTORY**: **"Yes"** responses to questions in this section require the following documentation:

____ **Self-Report:** Applicants who have listed offenses on the application must submit a letter in her/his own words describing the circumstances of the offense.

____ **Final Dispositions/Arrest Records:** The applicant must obtain and submit arrest and final disposition records for all offenses listed from the Clerk of the Court in the arresting jurisdiction. If the records are not available, you must have a letter on court letterhead sent from the Clerk of the Court attesting to their unavailability.

____ **Completion of Sentence Documents:** Provide written documentation that you have completed your probation/sentence requirements. You may obtain probation documents by contacting your probation office or the Department of Corrections. The report must include the start date, end date and that conditions were met.

____ **Letters of Recommendation:** Submit three letters of professional recommendation on official letterhead from employers, nursing program administrators, nursing instructors, health professionals, professional counselors, support group sponsors, parole or probation officers, or other individuals in positions of authority who are familiar with your past and present character. Letters should be current within the last year.

(Section 10)

________ **DISCIPLINARY HISTORY**: Any applicant who has ever had disciplinary action or surrendered a license to practice in any healthcare profession, in any state, jurisdiction, or country must provide a self explanation of all occurrences of disciplinary action or surrendering of a license. The State Board(s) of Nursing involved must also submit copies of the Administrative Complaint and Final Order directly to the Florida Board. Applicants are responsible to ensure that the proper documentation is sent to the Florida Board. Any action taken against your license by a state licensing board must be reported on this application.

____ **Self-Report:** Applicants who have listed discipline on the application must submit a letter in her/his own words describing the circumstances behind the discipline.

(Section 11)

________ **CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS**:
IMPORTANT NOTICE: Effective July 1, 2009, section 456.0635, Florida Statutes, provides that health care boards or the department shall refuse to issue a license, certificate or registration and shall refuse to admit a candidate for examination if the applicant has been:

1. Convicted or plead guilty or nolo contendere to a felony violation of: chapters 409, 817, or 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss 1395-1396, unless the sentence and any probation or pleas ended more than 15 years prior to the application.

2. Terminated for cause from Florida Medicaid Program (unless the applicant has been in good standing for the most recent five years).

3. Terminated for cause by any other State Medicaid Program or the Medicare Program (unless the termination was at least 20 years prior to the date of the application and the applicant has been in good standing with the program for the most recent five years).

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

(Section 12)

________ **SOCIAL SECURITY PAGE**: All applicants are required to complete this page. The information you provide us on this page is confidential. If you do not have a United States Social Security Number you are required to obtain one prior to the issuance of a permanent license.

(Section 13)

________ **HEALTH HISTORY**: All applicants for licensure must complete this section on the application. Supporting documentation related to any “Yes” answer must be submitted to the Board of Nursing, 4052 Bald Cypress Way, Bin C-02, Tallahassee, FL 32399-3252. Supporting documentation must include a letter from the applicant explaining the medical condition(s) or occurrence(s) and current status; letter(s) from licensed professional(s) summarizing diagnosis, treatment and prognosis; or any other official documentation as it relates to any “Yes” answer. Documentation should be current within the last year.

________ **APPLICANT SIGNATURE**: The application must be signed by the applicant before submission. Failure to do so will result in a delay in processing of your application. Be sure the same name used on your application is on each document.

SUPPLEMENTAL FORMS:

_________ **Fingerprint Cards:** All applicants must complete two (2) fingerprint cards, per Florida Statutes 464.009(3). Failure to submit fingerprint cards will delay your application. Your local law enforcement agency will roll your fingerprints, and may charge you a fee. When you contact your local law enforcement agency, confirm that they have the FD-258 fingerprint cards. If the cards are unavailable, you may order blank fingerprint cards for a fee at www.fldoh.sofn.net.

All applicants are required to log on to the internet site: www.fldoh.sofn.net to enter profile information. Print out the resulting barcode sheet, and mail it with your completed fingerprint cards to our office at:

Florida Board of Nursing
4052 Bald Cypress Way, Bin C-02
Tallahassee, FL 32399-3252

Entering your profile information is free and will ensure that your personal data is correctly entered. If you do not have access to the internet at home or work, you can use a computer at your local public library. Handle your fingerprint cards with the utmost care and mail them to our address in a flat envelope. Smudged, folded, or bent cards may result in rejected results making resubmission necessary.

_________ **License Verification Form (FL RN licensees do NOT need to submit this)**: The Florida Board of Nursing requires verification of licensure from your original state of licensure and from a state in which you have a current active license (they can be the same state). You may need to use one or both of the verification methods listed below to have your license verification sent to Florida.

NURSYS™ (Nurse System) - A computer system that contains nurse license and license discipline information that is provided by boards of nursing in the United States and its territories. NURSYS™ receives regular updates of nurses' personal (name, address, etc.) and license information from participating boards of nursing. Florida is a participating member of NURSYS™. Request forms may be filled out online at www.nursys.com.

NURSING LICENSE VERIFICATION FORM- Use this form only if your state is not listed on the NURSYS system. Complete Part I of this form and send it to your **original and active** state(s) of licensure. Contact the appropriate State Board(s) of Nursing through the National Council of State Board of Nursing website at www.ncsbn.org to determine the fee for verification of licensure. The form(s) should be returned directly to the Florida Board of Nursing at the address listed in Part II of this form by the state verifying the licensure.

_________ **Transcript Request Form**: This form is only for Nurse Anesthetists and Nurse Midwives who are new graduates (within 12 months from the date your application is received) from a non-Florida school and are not yet nationally certified.

_________ **Verification of Successful Completion**: This form is only for Nurse Anesthetists and Nurse Midwives who are new graduates (within 12 months from the date your application is received) from a non-Florida school and are not yet nationally certified.

_______ **Financial Responsibility**: Indicate your level of financial responsibility or choose the appropriate exemption category. This form is **required** for licensure in Florida.

_________ **Dispensing Practitioner Registration**: Form DH-MQA 1185, 03/09 Rule 64B9-4.011 FAC- A practitioner who writes prescriptions or provides complimentary samples is **not** a "dispensing practitioner", and therefore does not need to register as a dispensing practitioner with the department. **Dispensing is** defined as selling medicinal drugs to patients in the office. If you wish to be a dispensing practitioner you will need to submit the fee and the application found on our website at www.doh.state.fl.us/mqa/nursing/frm_ARNPdisp_regis.pdf.

The Florida Center for Nursing is the definitive source for information, research, and strategies addressing the dynamic nurse workforce needs in Florida. The Center conducts multiple annual and biennial research projects, including nurse employer and nursing program surveys, to provide a comprehensive look at Florida's nurse population.

Based on this research, the Center projects a severe nursing shortage in Florida – a shortage that could have a devastating impact on healthcare quality and access for Florida's residents. The Florida Center for Nursing also uses the research it produces to address issues of supply and demand and utilization of scarce nurse workforce resources throughout the state.

In addition to nurse workforce research, the Florida Center for Nursing aims to improve the retention and recruitment of nurses in Florida through funding small grants and also by collecting and disseminating information on best practices and innovative strategies for nurse retention and recruitment. Increasing production of new nurses alone will not resolve the shortage. Efforts must be taken to retain the experiential knowledge of our existing nurses.

To learn more about Florida's nursing shortage and suggested solutions, for more information about the Center, and to understand how your contribution will be put to work, please visit the Center's website at www.FLCenterForNursing.org/donors.

The Florida Center for Nursing's operating revenues is derived in part from your donation. In order for the Florida Center for Nursing to continue its work on behalf of nurses, please donate by going to their web site or by adding your donation to the fee sheet enclosed in this application.

If you wish to donate you can do so in one of two ways:

- Log on to the Florida Center for Nursing's website and donate http://www.flcenterfornursing.org/donors/
- Include your donation with your application fee and indicate your donation on the fee sheet.

APPLICATIONS ARE PROCESSED IN DATE ORDER RECEIVED. PLEASE TYPE OR PRINT IN BLUE OR BLACK INK

(FOR REVENUE RECEIPTING ONLY)

DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
FLORIDA BOARD OF NURSING
Post Office Box 6330
Tallahassee, FL 32314
(850) 245-4125
www.doh.state.fl.us/mqa/nursing

FAILURE TO SUBMIT FEES (SEE INSTRUCTIONS), TO COMPLETE THIS APPLICATION, OR TO ATTACH ANY REQUIRED DOCUMENTATION WILL RESULT IN AN INCOMPLETE APPLICATION. YOUR APPLICATION WILL NOT BE CONSIDERED FOR APPROVAL UNTIL IT IS COMPLETE.

APPLICATION TYPE: (Check one only) Indicate below the type of license you wish to use to qualify for licensure in the State of Florida. See instructions for eligibility requirements.

☐ **Dual** Registered Nurse (RN)/Advanced Registered Nurse Practitioner (ARNP) (1701) **$318.00**

☐ Advanced Registered Nurse Practitioner (must have a Florida RN) (1701) **$143.00**

1. PERSONAL INFORMATION

NAME: Last/Surname___________________________________ First______________________________ Middle_________________

DATE OF BIRTH (MM/DD/YY) ______________________________ **E-MAIL ADDRESS** _____________________________________

MAILING ADDRESS: ____ Apt. No.______________________

City_______________________________________ State_______________ Zip_______________ Country______________________

PHYSICAL LOCATION:____ Apt. No. ______________________
(Required if mailing address is a P.O. Box-See Checklist)

City _______________________________________ State ______________ Zip _______________ Country _____________________

HOME TELEPHONE: _________________________________ **WORK TELEPHONE:** ____

PLACE OF BIRTH: ___________________________________ **MOTHER'S MAIDEN NAME:** ____________________________________

Availability for Disaster: ☐ Yes ☐ No Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☐ Female RACE: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other ___________

Do you want to donate to the Florida Center for Nursing? ☐ Yes ☐ No
(You will find directions in the application instructions on how to do so.)

2.

SPECIALTY TYPE: _____ **NURSE ANESTHETIST** _____ **NURSE MIDWIFE**

_____**NURSE PRACTITIONER (**Area of clinical specialization, Ex. Family, Pediatric, Adult, OB/GYN) _________________

NAME ____

3. LICENSURE HISTORY

A. What year did you first begin practicing as an Advanced Registered Nurse Practitioner? ________________

B. Florida RN License Number (if applicable): ________________

C. Are you nationally certified by one of the recognized certifying bodies? ☐ Yes ☐ No

D. Certifying board(s) _____________________________________ Original Certification date ________________

4. APPLICANT BACKGROUND (attach additional sheets, if necessary)

A. List any other name(s) by which you have been known in the past.____

____

B. What name(s) did you use when you received your nursing education? _______________________________________

C. List all professional licenses to practice (**active, inactive or lapsed**). (attach additional sheet, if necessary)

State/Country	License No.	RN or LPN	Date Of Licensure	If no longer licensed, state why & when

D. In which state did you take the RN exam? ____

E. ☐ Yes ☐ No Have you ever been denied or is there now any proceeding to deny your application for any healthcare license to practice in Florida or any other state, jurisdiction or country?

5. MANDATORY CONTINUING EDUCATION REQUIREMENT

Completion of a two-hour course on Prevention of Medical Errors is required prior to licensure as required by Florida Statute. This course must be from an approved Florida Board of Nursing provider.

☐ I attest I have completed a 2 hour course in the Prevention of Medical Errors.

☐ I have **not** completed a 2 hour course in the Prevention of Medical Errors and I understand that I will not receive my license until I submit proof of completion.

Note: Additional continuing education requirements affect your renewal. See Chapter 64B9-5, F.A.C.

6. BASIC NURSING EDUCATION (attach additional sheet, if necessary)

A. NURSING SCHOOL ATTENDED: ____

B. Address of School:

____
Street address City State Zip Code

C. Type of Degree or Certificate (ex: ADN or BSN) _________ D. Date Graduated ________________

POST BASIC CERTIFICATE, GRADUATE, OR POST GRADUATE EDUCATION (NURSING)

E. NURSING SCHOOL ATTENDED:

____

F. Address of School:

____
Street address City State Zip Code

G. Type of Degree or Certificate (ex: MSN or post masters) __________ H. Date Graduated ____________________

NAME ____

7. FACULTY APPOINTMENTS

A. List any current faculty appointments including preceptor roles or enter N/A.

Title of Appointment ________________ Institution ____________________ City & State _________________

Title of Appointment ________________ Institution ____________________ City & State _________________

B. List any responsibility you have had for graduated education within the last 10 years.

Title of Appointment ________________ Institution ____________________ City & State _________________

Title of Appointment ________________ Institution ____________________ City & State _________________

8. LIABILITY CLAIMS

☐ Yes ☐ No Within the last ten (10) years, have you had any professional liability claims in excess of $5000? If yes attach an explanation to include: nature of claim, incident date, county, judicial case number, settlement date, settlement amount; and the statutory explanation of why the settlement occurred.

9. CRIMINAL HISTORY

A. ☐ Yes ☐ No Have you **EVER** been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. **Driving under the influence (DUI) or driving while impaired (DWI) is not a minor traffic offense for purposes of this question.** (Review Questions & Answers section in instructions.)

If you answered YES, you are required to send a letter in your own words describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results. You must submit documentation for the county clerk of courts in the jurisdiction (state/county) in which the offense occurred, including disposition/final results. **Your application will not be considered complete until these records are received.** If the records are no longer available, you must obtain a letter of their unavailability from the county clerk of the court.

Please review the questions regarding criminal history carefully. If you are unable to determine how to answer the questions you will need to review the court documents from the clerk of the court. If you no longer have copies of the court documents, you should request them from the clerk of the court in the county in which the offense(s) occurred.

NAME ____

10. DISCIPLINARY HISTORY *Attach additional sheets, if necessary*

A. ☐ Yes ☐ No Do you have any disciplinary action pending against your license?

B. ☐ Yes ☐ No Have you ever had disciplinary action taken against your license to practice any health care related profession by the licensing authority in Florida or in any other state, jurisdiction or country?

If "Yes" list each final disciplinary action taken against you by a regulatory agency.

	Agency	Date	Description of Violation	Description of Action	Under Appeal?
1.					Yes ☐ No ☐
2.					Yes ☐ No ☐
3.					Yes ☐ No ☐

C. ☐ Yes ☐ No Have you ever had any final disciplinary action taken against you by an institution such as a licensed hospital, health maintenance organization, pre-paid health clinic, ambulatory surgical center, or nursing home?

If "Yes" list each final disciplinary action taken against you by a facility or organization.

	Institution	Date	Description of Violation	Description of Action	Under Appeal?
4.					Yes ☐ No ☐
5.					Yes ☐ No ☐
6.					Yes ☐ No ☐

D. ☐ Yes ☐ No Have you ever had any final disciplinary action been taken against you by a national nursing specialty board that is recognized by any board of nursing?

If "Yes" list each final disciplinary action taken against you by a specialty board.

	Specialty Board	Date	Description of Violation	Description of Action	Under Appeal?
7.					Yes ☐ No ☐
8.					Yes ☐ No ☐

E. ☐ Yes ☐ No Within the previous ten years have you ever been allowed to or asked to resign from any facility instead of disciplinary action or during any pending investigation into your practice?

NAME ____

11. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer "Yes" to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

1. ☐ Yes ☐ No a. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication to, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If "No", do not answer 1b.)

   ☐ Yes ☐ No b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction?

2. ☐ Yes ☐ No a. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 2b.)

   ☐ Yes ☐ No b. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

3. ☐ Yes ☐ No a. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If "No", do not answer 3b and 3c.)

   ☐ Yes ☐ No b. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?

   ☐ Yes ☐ No c. Did the termination occur at least 20 years prior to the date of this application?

12.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

* The following pages are exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USC § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Board of Nursing

Name: ____

Last **First** **Middle**

Social Security Number: ______________________________

Social Security Information - *Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Mission Statement: To promote and protect the health, safety, and wellness of all people in Florida.

4052 Bald Cypress Way, Bin # C02
Tallahassee, Florida 32399-3252
Phone: (850) 245-4125 Fax: (850) 245-4172

Website: www.doh.state.fl.us/mqa/nursing

NAME ____

13. HEALTH HISTORY (Supporting documentation should be sent directly to the Board Office).

Supporting documentation must include a letter **from the applicant** explaining the medical condition(s) or occurrence(s) **and** current status; letter(s**) from licensed professional** summarizing diagnosis, treatment and prognosis; or any other official documentation **as it relates to any "Yes" answer**. Documentation should be current within the last year.

A. ☐ Yes ☐ No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

B. ☐ Yes ☐ No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

C. ☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your

ability to practice nursing within the past five years?

D. ☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice nursing?

E. ☐ Yes ☐ No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

F. ☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice nursing within the past five years?

NAME ____

CERTIFICATION STATEMENT

I, the undersigned, state that I am the person referred to in this application for licensure in the State of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083 and 775.084, Florida Statutes.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in the is application I hereby agree that such act shall constituted cause for denial, suspension or revocation of my license to practice as a Registered Nurse or Advanced Practice Nurse in the State of Florida.

I further state that I have read and understand Chapter 464, Florida Statutes, and Rule 64B9, Florida Administrative Code as they pertain to the practice of nursing and advanced practice nursing.

Florida Law requires you to immediately inform the Board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I will comply with all requirements for licensure and renewal including continuing education credits.

Applicants Signature ____ **Date** _____________________

Application Fee Sheet

Name ___________________________

FEES	Endorsement RN & ARNP	ARNP Only Must have current Florida RN License
RN Processing Fee	90.00	--
RN Initial Licensure Fee	75.00	--
Criminal Background Check	43.00	43.00
Student Loan Forgiveness Fund	5.00	
Unlicensed Activity Fee	5.00	
ARNP application fee	$100.00	$100.00
Subtotal	$318.00	$143.00
Voluntary Contribution to support the Florida Center for Nursing	$	$
Optional Dispensing Practitioner	$100.00	$100.00
TOTAL ENCLOSED	$	$

Withdrawal and refund of applications

If you decide to withdraw your application, you must make the request in writing. The request must be received prior to the Board's granting of licensure. Withdrawal of the application prior to completion entitles an applicant to a refund of $85.00 (initial licensure, student loan forgiveness and unlicensed activity fees) (**Dual applicants only**). Included in the request should be a request for refund of the appropriate fees. **Do not stop payment on your cashier's check or money order.** This could result in a "bad check charge" being filed against you. Applicants with confirmed arrest or disciplinary histories cannot withdraw without permission of the Board.

Mailing Instructions

Send cashier's check or money order payable to: DOH Florida Board of Nursing. You may send one cashier's check or money order to cover the total fees above. **Sending the fees to an address other than the P.O. Box listed below will delay your application**. All applications and correspondence with fees enclosed must be sent to:

Department of Health
Post Office Box 6330
Tallahassee, FL 32314

Telephone Number: 850-245-4125
Fax Number: 850-245-4172
Web Site: www.doh.state.fl.us/mqa/nursing

DH-MQA 1124, 10/11, Rule 64B9-4.002 FAC

NURSING LICENSE VERIFICATION REQUEST

****Important- Please DO NOT use this form if your state is listed on NURSYS, visit www.nursys.com****

PART I: TO BE COMPLETED BY APPLICANT

Send to your original and current state(s) of licensure (not Florida). Make Copies as necessary.

Applicant Name____ SS#_______________________

Address____

Name original license was issued under____

License Number____ State of ________________________

I hereby authorize release of any information regarding my licensure status to the Florida Board of Nursing.

Applicant Signature____ Date __________________

****

PART II: All verifications shall be completed in English and mailed or sent electronically directly from the state(s) or jurisdiction(s) and must include the following criteria:

* Typed on an official state form or letterhead
* Include an official Board seal.
* Signature and title of state Board official

The following information must be included in all verifications:
* Licensee name
* License number
* State or jurisdiction of licensure
* Level of licensure (RN/LPN)
* Dates of issuance/expiration
* Licensure method (state exam, national exam, endorsement, reciprocity)
* Licensure status
* Is license in good standing?
* Has this license ever been encumbered (denied, revoked, suspended surrendered, limited, placed on probation)?

*__Complete verifications must be mailed directly from the official state licensure Board to:__

Florida Board of Nursing
4052 Bald Cypress Way
Bin # C02
Tallahassee, FL 32399-3252

*If this license has ever been encumbered please forward all orders to the Florida Board of Nursing with this form.

DH-MQA 1124, 10/11, Rule 64B9-4.002 FAC

Florida Board of Nursing
Transcript Request Form
(For applicants graduating from a School outside of Florida)

Please forward an official copy of my transcripts to:
Florida Board of Nursing
4052 Bald Cypress Way
Bin # C02 - ARNP
Tallahassee, FL 32399-3252

Name:____________________________________ Social Security Number _____-____-_____

Street address:____ Apt #______________

City:________________________________ State:___________________ Zip______________

Graduation Date:_________________________

Name in school if different from above: ____

I authorize the school to release the information requested below to the Florida Board of Nursing

Signature of Student:____

The following information must be on the official transcript.

- All general education and nursing courses with semester credit hours or contact and grades reported
- Beginning and ending dates of study
- Graduation or withdrawal date
- Degree, certificate or diploma conferred, if applicable

Please return this form along with the transcript.

VERIFICATION OF SUCCESSFUL COMPLETION
ADVANCED REGISTERED NURSE PRACTITIONER PROGRAM

SECTION I - To be completed by the applicant (This form is only for Nurse Anesthetist or Nurse Midwife applicants who are new graduates, who are not nationally certified and graduated from a non-Florida School).

Mail form to the educational institution you attended to complete Section II - IV.

Last Name__________________ First _________________ Middle ______________ Maiden ___________

Address (*number and street*) ____

City _____________________________ State ___________________ Zip Code ______________________

Social Security Number (*optional*) ______________________ or School ID number______________________

I authorize my school/program to release the information requested below to the Florida Board of Nursing.

Signature ____ Date _________________________

SECTION II GENERAL PROGRAM INFORMATION

Name of Applicant ____

Certificate/Degree Awarded (*specify*) __________________________________ Date
____

Name of School ____

Mailing Address____

School Accreditation (*name of agency of association*)____

Approval/expiration dates ____

LECTURE/DIDACTIC (*total # classroom hours or academic credits awarded*) _________________________

SUPERVISED CLINICAL PRACTICE (*# of hours*) ___________

PRECEPTORSHIP (*beginning date-completion date*)___________________ (*total # hours*) _____________

Site(s):____

SECTION III **PROGRAM CHARACTERISTICS**

Clinical Specialization ____

CHECK THE ANSWER	YES	NO
1. Was the program at least one academic year in length?		
2. Did the program include theory in the biological, behavioral, nursing and medical sciences?		
3. Did the applicant have clinical experience with a qualified preceptor?		
4. Is the philosophy, purpose and objectives clearly defined and available in written form?		
5. Were the objectives clearly defined and available in written form?		
6. Did faculty include currently practicing ARNPs?		
7. Were records of the program, philosophy, objectives, administration, faculty, curriculum, students, and graduates maintained systematically?		
8. Are records retrievable?		

SECTION IV. CURRICULUM SCHOOL YEAR __________ SPECIALIZATION ________________________	SPECIFIC COURSE NUMBER(S) THAT CORRELATE WITH TRANSCRIPTS
Identify the course where the following content/skills are taught: 1. Advanced physical assessment to include theory and directed clinical experience.	
2. Interviewing and communication skills relevant to obtaining and maintaining a health history.	
3. Advanced pharmacology, to include selecting, prescribing, initiating, and modifying medications in the management of health/illness.	
4. Performance of specialized diagnostic tests that are essential to the area of advanced practice.	
5. Interpretation of laboratory findings.	
6. Differential diagnosis pertinent to the specialty area.	
7. Management of selected diseases, illnesses and conditions.	
8. Selecting, initiating and modifying therapies and diets in the management of health/illness.	
9. Professional socialization/role realignment.	
10. Legal implications of the advanced nursing practice/nurse practitioner.	
11. Health delivery systems, including assessment of community resources and referrals to appropriate professionals or agencies.	
12. Providing emergency treatments as appropriate to the advanced practice nursing specialty area.	

OFFICIAL SCHOOL SEAL

Director Signature ____

Printed Name ____

Title ____

Telephone ____

Name: ________________________________
License No.: ___________________________

FINANCIAL RESPONSIBILITY
Advanced Registered Nurse Practitioners

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only **ONE** option that best describes your situation. If you provided financial responsibility information to a hospital or elsewhere, please be consistent when choosing an option below.

Please be advised, failing to choose an option or choosing more than one option will delay your renewal. Department staff is unable to advise you on which option to choose. If you have questions regarding choosing an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and will maintain Professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 from an authorized insurer under Section 624.09, F.S., a surplus lines insurer under Section 626.914(2), F.S., a joint underwriting association under Section 627.351(4), F.S., a self-insurance plan under Section 627.357, F.S., or a risk retention group under Section 627.942, F.S.

☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined by Chapter 675, F.S. which is in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the ARNP as beneficiary.

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

☐ 1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. I hold a limited license issued pursuant to s.456.015, F.S. and practice only under the scope of the limited license.

☐ 3. My Florida license is inactive and I do not practice in the State of Florida.

☐ 4. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

☐ 5. My Florida license is active, but I do not practice in the State of Florida.

☐ 6. I have had no malpractice exposure in the state and can demonstrate to the Board or department my lack of malpractice exposure.

I certify that these statements are true and correct and recognize that providing false information may result in disciplinary action or criminal penalties as provided in Sections 456.067, 456.072, Florida Statutes.

________________________________ ____________________

Signature of Licensee Date