

## APPLICATION INSTRUCTIONS FOR RETIRED VOLUNTEER NURSE CERTIFICATION

- **Please read all application instructions** and the statutory requirements for eligibility for certification as a Retired Volunteer Nurse before you complete the application.
- **No application is complete until all portions of the application are filled in, the fee is received, and a copy of a nursing license attached.** An incomplete application will delay final approval of the application. If additional documents are required, processing will not continue until they are received. All questions must be answered honestly.
- **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. Examples: change of name, address, or telephone number, licensure status or disciplinary action in another state.

### GENERAL INFORMATION

#### **Eligibility Requirements**

Any retired practical or registered nurse desiring to serve indigent, underserved, or critical need populations in Florida may apply to the Department of Health for a retired volunteer nurse certificate by providing:

1. A complete application.
2. Level II Background Check – Florida Statute 464.009(3) requires a Level II Background Check on all nurses in Florida. Please request a fingerprint card on line or call 850 488-0595 and request one. There is a \$48 fee. If you have had a background check for your employer (a state agency, within the last six months), we can accept a copy of the FBI and FDLE reports directly from another state agency.
3. Verification that the applicant has been licensed to practice nursing in any jurisdiction in the United States for at least 10 years. If licensed in states other than Florida, please have license verifications provided to confirm 10 years of practice.
4. Has retired or plans to retire.
5. Intends to practice nursing only pursuant to the limitations provided by the retired volunteer nurse certificate. Letter from the hiring agency stating what position the Retired Volunteer Nurse will hold or has been offered.
6. Has not committed any act that would constitute a violation of the nurse practice act. If you have had disciplinary action taken against your license or if you have had a license denied, you must submit documentation that explains the reasons for such action(s). This would include copies of the administrative complaint and final order of the Board involved.

**Practice Constraints** A retired volunteer nurse **must**:

1. Work under the direct supervision of a Florida licensed physician; advanced registered nurse practitioner, or registered nurse;
2. Comply with minimum standards of practice for nurses and be subject to disciplinary action for violations of the nurse practice act;
3. Limit practice to primary and preventive health care;
4. Work only in settings for which there are provisions for professional liability coverage for acts or omissions;
5. Provide services in settings for indigent, underserved, or critical need populations.
- 6.

**Mailing Instructions** - The application, fingerprint card, and fee should be mailed to:

Department of Health  
Board of Nursing  
Post Office Box 6330  
Tallahassee, Florida 32314-6330

#### **Certification Letter**

- As proof of certification, you will receive a letter from the Board stating you have met eligibility requirements. **It will be embossed with the Board's seal to insure its authenticity.** The letter will allow you to work as a retired volunteer nurse. You are permitted to work only under the restrictions established by Florida law.

## APPLICATION CHECKLIST

\_\_\_\_\_ **Application** - All sections have been completely, clearly, and accurately answered. All items have been filled in. All boxes have been checked. You have signed and dated the application.

\_\_\_\_\_ **Verification Form** - If you are not a Florida licensed nurse or if your original state of licensure was Florida, but you were licensed in Florida less than ten years, you have completed the verification form(s) and sent them to the appropriate state(s) with any fee required by that state.

\_\_\_\_\_ **Employment letter** - Letter from the hiring agency stating what position the Retired Volunteer Nurse will hold or has been offered.

\_\_\_\_\_ **Appropriate Fee** - The appropriate fee paid by check, money order, or cashiers check is attached to the application.

\_\_\_\_\_ **Mailing Address** - The envelope is addressed to the Board of Nursing at the address above.

\_\_\_\_\_ **Level II Background Check** – Florida Statute 464.009(3) requires a Level II Background Check on all nurses in Florida. Please request a fingerprint card on line or call 850 488-0595 and request one. There is a \$48 fee. If you have a background check for your employer (a state agency, within the last six months) we can accept a copy of the FBI and FDLE reports directly from another state agency.

\_\_\_\_\_ **Mandatory Continuing Education** -Per sections 456.013(7), 456.604 and 456.597, Florida Statutes, all applicants must submit evidence of completion of mandatory continuing education courses from an approved provider within the past 24 months: Two (2) hours on Prevention of Medical Errors. HIV/AIDS 1-hour CE requirement to be completed prior to the first renewal. Domestic Violence CE is now a 2-hour requirement every third renewal.

**You will be notified within 30 days if additional information is needed to process your application.**

**APPLICATION FOR RETIRED VOLUNTEER NURSE CERTIFICATE**  
**Florida Board of Nursing**  
**4052 Bald Cypress Way, Bin C02**  
**Tallahassee, Florida 32399**

*Please Type or Print in Blue or Black Ink*

<b>1. PROFILE INFORMATION</b>											
NAME: Last _____ First _____ Middle _____											
MAILING ADDRESS: _____ Apt. No. _____											
City _____ State _____ Zip _____ Country _____											
HOME TELEPHONE: _____ WORK TELEPHONE: _____											
PRACTICE LOCATION: _____											
City _____ State _____ Zip _____											
DATE OF BIRTH (M/D/Y) _____ PLACE OF BIRTH: _____											
<b>2. LICENSURE INFORMATION</b>											
ORIGINAL STATE OF LICENSURE: _____ DATE OF ORIGINAL LICENSURE _____											
List all nursing licenses (Use additional paper, if necessary)											
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>State/Country</u></th> <th style="text-align: left;"><u>License No.</u></th> <th style="text-align: left;"><u>RN/LPN</u></th> <th style="text-align: left;"><u>Date of Licensure</u></th> <th style="text-align: left;"><u>If no longer licensed, reason</u></th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		<u>State/Country</u>	<u>License No.</u>	<u>RN/LPN</u>	<u>Date of Licensure</u>	<u>If no longer licensed, reason</u>					
<u>State/Country</u>	<u>License No.</u>	<u>RN/LPN</u>	<u>Date of Licensure</u>	<u>If no longer licensed, reason</u>							
Have you ever had disciplinary action taken against your license or had a license denied? Yes <input type="checkbox"/> No <input type="checkbox"/>											
If yes, explain (Use additional paper, if necessary) _____											
<b>3. REQUIREMENTS OF RETIRED VOLUNTEER NURSE CERTIFICATE</b>											
A. I have been licensed to practice nursing for at least 10 years and will practice nursing only pursuant to limitations provided by the retired volunteer nurse certificate. Yes <input type="checkbox"/> No <input type="checkbox"/>											
B. I plan to retire or have retired and intend to practice with indigent, underserved or critical needs patients for no compensation. Yes <input type="checkbox"/> No <input type="checkbox"/>											
C. I agree to work under the direct supervision of a physician, ARNP, or RN. Yes <input type="checkbox"/> No <input type="checkbox"/>											
D. I agree to work only in settings for which there are provisions for professional liability coverage for acts or omissions of the retired volunteer nurse. Yes <input type="checkbox"/> No <input type="checkbox"/>											
E. I agree that I <u>will not</u> : a. administer controlled substances; b. supervise other nurses; or c. receive monetary compensation. Yes <input type="checkbox"/> No <input type="checkbox"/>											
F. I am in good mental and physical health and able to practice nursing safely. Yes <input type="checkbox"/> No <input type="checkbox"/>											
G. I have completed continuing education in HIV/AIDS, Domestic Violence and Prevention of Medical Errors from an approved Florida Board of Nursing Provider and documentation is attached. Yes <input type="checkbox"/> Note: Certificate will not be issued until documentation is received.											
<b>SIGNATURE</b> _____	<b>DATE</b> _____										
DOH 20314 11/07											



CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS  
DISCLOSURE\*

Florida Department of Health  
Board of Nursing

Name: \_\_\_\_\_  
                    Last                                    First                                    Middle

Social Security Number: \_\_\_\_\_

\* This page is exempt from public records disclosure pursuant to subparagraph 119.071(5)(a)2., Florida Statutes, which provides in relevant part: "An agency that collects social security numbers shall also segregate that number on a separate page from the rest of the record, or as otherwise appropriate, in order that the social security number be more easily redacted, if required, pursuant to a public records request."

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Mission Statement: To protect and promote the health of all persons in Florida by diligently regulating health care practitioners and facilities.

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](http://www.doh.state.fl.us/mqa/nursing)