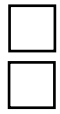

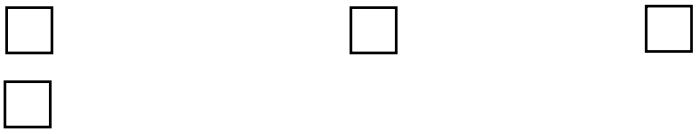

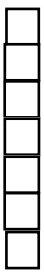

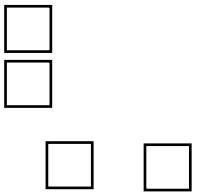

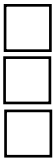

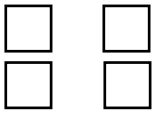

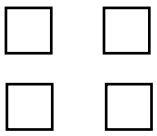

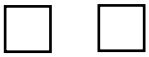

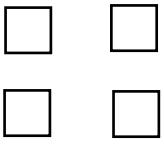

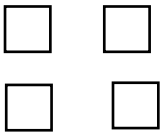

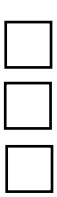

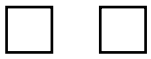

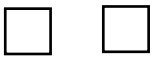

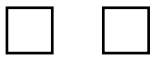

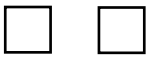

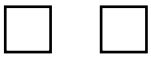

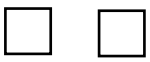

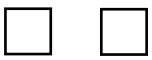

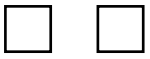

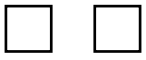

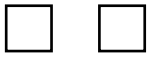

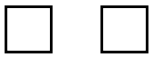

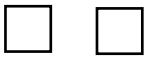

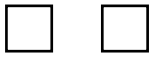

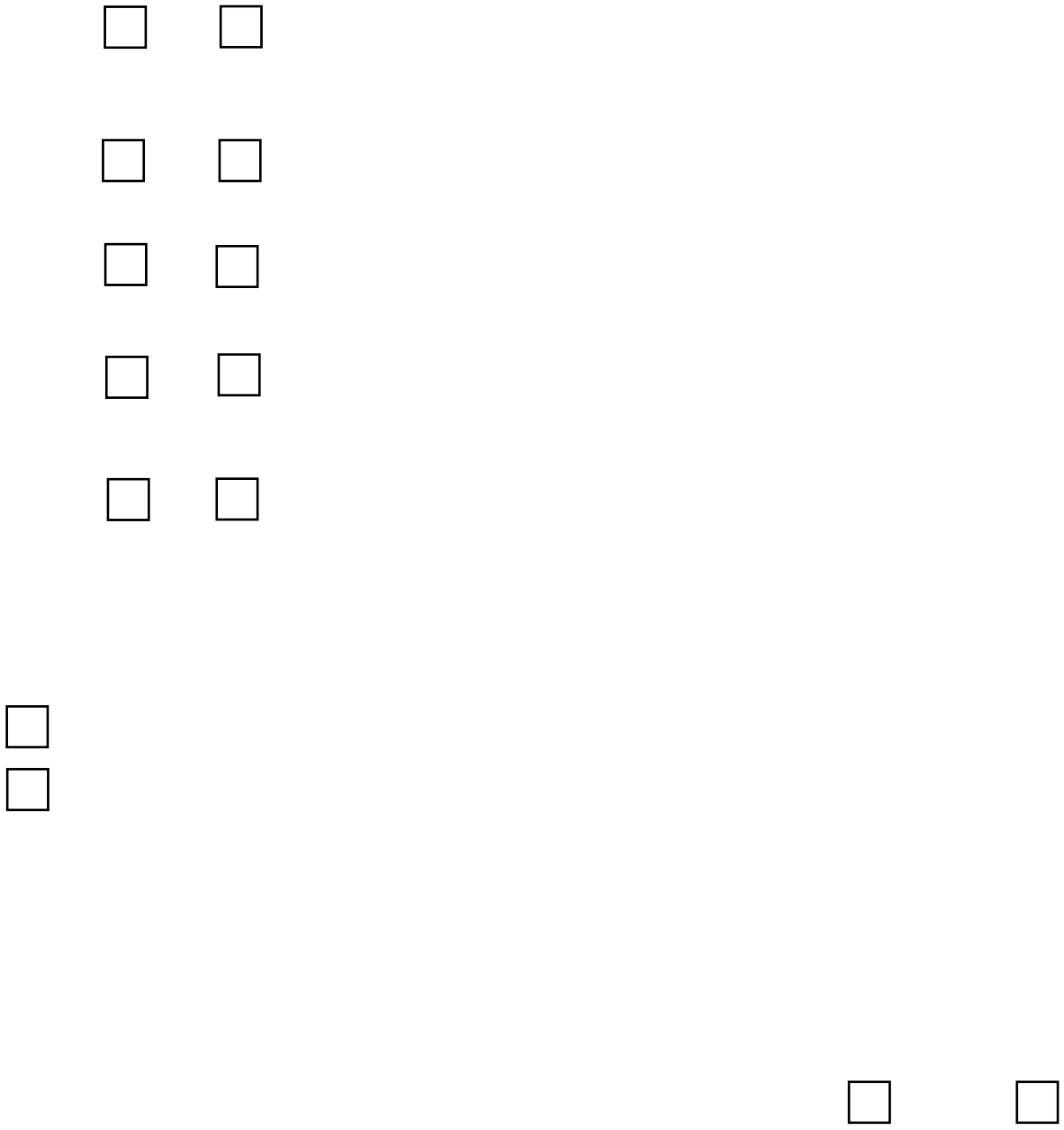

FINANCIAL RESPONSIBILITY
Advanced Registered Nurse Practitioners

This form is mandatory for all applicants.

Name: _____

License Number or Applicant ID: _____

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 licensure. 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 just completed my Advanced Registered Nurse Practitioner Program and/or I am not yet practicing in Florida.

456.067 Penalty for giving false information. In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, the act of knowingly giving false information in the course of applying for or obtaining a license from the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her official duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.08.

Signature of Licensee: _____

VERIFICATION OF SUCCESSFUL COMPLETION
ADVANCED REGISTERED NURSE PRACTITIONER PROGRAM

Who needs to use this form?

- Nurse Anesthetist or Nurse Midwife applicants who are not yet nationally certified and graduated within the past year.

Section I. To be completed by the applicant- After you have completed section one, m**ail form to the educational institution you attended to complete all other sections.**

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 School: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Certificate/Degree Awarded (*specify*): _____ Date: _____

Name of certifying body school is accredited by: _____

Approval/expiration dates: _____

Total Number of Lecture/Didactic *Classroom Hours or Academic Credits Awarded*: _____

Number of Supervised Clinical Practice Hours: _____

Preceptorship (*beginning date-completion date*): _____ (*total # hours*): _____

Site(s): _____

Clinical Specialization: _____

Name: _____

Section III. Program Characteristics

Place a check mark in the appropriate box.

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

Name: _____

Section IV. Curriculum

Identify the course (specific course number(s) that correspond with the transcript) 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's Name: _____

Title: _____

Telephone: _____

Director' Signature: _____ Date: _____

Complete verifications must be mailed, or sent electronically, directly from the verifying agency to:

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

Florida Board of Nursing
License Verification Request

Who needs to use this form?

- Applicants whose state(s) do not participate in the Nursys system should use this form.
  - * All applicants are required to provide verification of their initial license and an active license.
  - * A large number of states verify licensure using the Nursys system. Applicants should check and see if their state participates in the Nursys system by logging on to www.nursys.com.
  - * Verification must be sent directly to our office by the verifying agency. **Copies of licenses and website screen shots do not meet the requirement for verification of licensure.**
  - * You are responsible for fees incurred for verification of your licensure.

PART I: TO BE COMPLETED BY APPLICANT (Send to your original and current state(s) of licensure. *No verification is required for previous Florida licenses.* Make copies as necessary.)

Applicant Name: _____ SSN:_____

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: TO BE COMPLETED BY YOUR STATE BOARD OF NURSING

All verifications must be in English and 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
* Licensure status
* Is license in good standing?
* Level of licensure (RN/LPN)
* Dates of issuance/expiration
* Licensure method (state exam, national exam, endorsement, reciprocity)
* Has this license ever been encumbered (denied, revoked, suspended surrendered, limited, placed on probation)?
* If this license has ever been encumbered please forward all orders to the Florida Board of Nursing with this form.

DH-MQA 1124, 06/16, Rule 64B9-4.002,

Complete verifications must be mailed directly from the verifying agency to:

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

Florida Board of Nursing
Employment Verification Request

Who needs to use this form?

- Applicants who have not taken the NCLEX, but have practiced in a U.S. State or Territory must show proof of work in a U.S. State or Territory for two (2) of the last three (3) years at the level (Licensed Practical Nurse/ Registered Nurse) of licensure as it relates to your application type.
- Applicants who have taken the SBTPE or NCLEX but do not have an ACTIVE license, and who have worked in the previous 5 years, must complete this form.
- Applicants who have taken the SBTPE or NCLEX and have an ACTIVE license DO NOT need to complete this form.

PART I: To be completed by applicant- Complete this part and submit a copy to each place you were employed during the last three years.

Applicant Name: _____ SSN: _____

Address: _____

Name of hospital or agency: _____

I hereby authorize release of any information regarding my employment status with your facility to the Florida Board of Nursing.

Applicant Signature: _____ Date: _____

PART II: To be completed by employer- All verifications must be in English and mailed directly from the hospital personnel office or agency/employer and must include the following criteria:

*** Typed on official agency letterhead with an original signature**
* Applicant Name
* Applicants Social Security number
* Indicate level of licensure while employed (Registered Nurse/Licensed Practical Nurse)
* Position title while employed
* Place of employment
* Address of employer to include: mailing address, city, state and zip code
* Employer's telephone number to include: area code and number
* Start and End dates of employment (month and year)
* Eligible for rehire? (Yes/No) If not eligible for rehire, please provide written details.
* Printed name of verifying agent
* Signature of verifying agent and date completed

DH-MQA 1124, 06/16, Rule 64B9-4.002, F.A.C.

Who needs to use this form?

- Nurse Anesthetist or Nurse Midwife applicants who are not yet nationally certified and graduated within the past year.

Florida Board of Nursing
Transcript Request Form

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: _____

Official transcripts must be in English and include the following information:

- 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.