Important Information for all Applicants

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.).

- All sections must be completed in full. If an item does not apply, indicate with N/A. **N/A is not an acceptable answer for "Yes" or "No" questions**. Failure to submit a complete application will result in a processing delay. If you provide false information, the Board of Nursing may deny your application.

- 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.

- Address changes must be submitted to the Board in writing using the form at: http://www.floridasnursing.gov/latest-news/frequently-asked-questions-and-how-tos/ The United States Postal Service will **NOT forward mail sent from our office. This mail will be returned to the Board office.**

- **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 license or a U.S. Social Security card.

- **Dispensing Practitioner Registration**: Form DH-MQA 1185, 03/09 Rule 64B9-4.011 F.A.C., 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: http://www.floridasnursing.gov/applications/disp-arnp-app.pdf

Florida Board of Nursing
PO Box 6330
Tallahassee, FL 32314
Phone: (850) 245-4125
Fax: (850) 617-6460

Dual Registered Nurse (RN) & Advanced Registered Nurse Practitioner (ARNP) Application

Website: www.floridasnursing.gov
Email: Mqa.NursingAppstatus@flhealth.gov

Please complete this application in its entirety prior to printing.

Do Not Write in this Space For Revenue Receipting Only

This application cannot be used to apply for Clinical Nurse Specialist (CNS). Find the CNS application on our website at: http://floridasnursing.gov/applications/cns-app.pdf

Choose your application type: (Check one only)

- ☐ Dual Registered Nurse (RN)/Advanced Registered Nurse Practitioner (ARNP) - (1701) $210.00
- ☐ Advanced Registered Nurse Practitioner (must have a Florida RN license) - (1701) $100.00

Choose your specialty type: (Check one only)

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

- ☐ Nurse Anesthetist
- ☐ Nurse Midwife
- ☐ Nurse Practitioner (Nationally Certified in: Ex. Family, Pediatric, Adult, OB/GYN) _____

1. PERSONAL INFORMATION

Name: _____ (Last/Surname) _____ (First) _____ (Middle) **Date of Birth:** _____ **(MM/DD/YYYY)**

Mailing Address: (Give the address where mail and your license should be sent)

_____ (Street **/P.O. Box**) _____ (Apt. No.) _____ (City)

_____ (State) _____ (Zip) _____ (Country) _____ Home/Cell Telephone **(Input number without dashes)**

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department's website.)

_____ (Street) _____ (Apt. No.) _____ (City)

_____ (State) _____ (Zip) _____ (Country) _____ Work/Cell Telephone **(Input number without dashes)**

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 _____

NAME _____

Email Notification: If you want to be notified of the status of your application by email please check the **"Yes"** box and write your email address on the line provided below. If you choose this form of notification you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the Board office at: **mqa.nursingappstatus@flhealth.gov**

I want to be notified by email only ☐ Yes ☐ No

Email Address: _____

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. LICENSURE HISTORY

A. What year did you first begin 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.) _____ (MM/YYYY)

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

Currently licensed Florida Registered Nurses (**Does not apply to Dual applicants**) - The ARNP certification is an upgrade of a current Florida Registered Nursing License. Therefore, if your Florida RN license is up for renewal or will be 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: www.flhealthsource.com

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

☐ Applicants must submit **Proof of National Certification.** It must be sent directly from the national certifying body or you can submit a copy of current certification (or recertification) card notarized as a "true and correct copy". Exam results are not considered proof of national certification.

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: www.flrules.org/gateway/Organization.asp?OrgNo=64B9

D. Certifying Board(s) _____

Original Certification date _____

(MM/DD/YY)

3. 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? _____

Dual Applicants Only- The Florida Board of Nursing requires verification of licensure from your original state of licensure (exam) and from a state where you have a current active license. Only (1) verification is required if your original state is current (active). **You may need to use one or both of the following methods to have your license verification sent to Florida.**

☐ Visit www.nursys.com and see if your state is listed. If your state(s) is listed register and pay the verification fee.

☐ Nursing License Verification Form: This form is for use with Non-NURSYS states and is found at the end of this application.

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?

*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.

_____

4. MANDATORY PREVENTION OF MEDICAL ERRORS REQUIREMENT

Completion of a two-hour course on the Prevention of Medical Errors is required prior to licensure. This course must be from an approved Florida Board of Nursing provider. Courses can be found online at www.CEbroker.com

☐ I have completed a 2 hour course on the Prevention of Medical Errors as required by Florida law.

* Applicants who check this box **do not need to** submit proof of completion.

☐ I have NOT completed a 2 hour course on the Prevention of Medical Errors as required by Florida law.

* Applicants who check this box **must subsequently submit** proof of completion.

NAME _____

5. NURSING EDUCATION (Attach additional sheet, if necessary)

A. BASIC NURSING SCHOOL ATTENDED: _____

B. Address of School:

_____ _____ _____ _____
Street address City State Zip Code

C. Program Type: ☐ ADN ☐ BSN D. Graduation Date _____ (MM/YYYY)

☐ Nurse practitioners who graduated on or after October 1, 1998 must have completed requirements for a **master's degree or post-master's certification**. Applicants who graduated 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.

E. POST BASIC CERTIFICATE, GRADUATE, OR POST GRADUATE EDUCATION SCHOOL ATTENDED:

_____

F. Address of School:

_____ _____ _____ _____
Street address City State Zip Code

G. Program Type: ☐ MSN ☐ Post Masters ☐ DNP H. Graduation Date _____ (MM/YYYY)

Provisional Licensure

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).

To qualify for provisional licensure requires the following:

☐ You are applying as a Nurse Anesthetist or Nurse Midwife

☐ You graduated within the previous 12 months of receipt of your application

☐ Your transcripts and Verification of Successful Completion forms are submitted directly to the Board office from your educational institution

NAME _____

6. FACULTY APPOINTMENTS

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

Appointment Title _____ Institution _____ City & State _____

Appointment Title _____ Institution _____ City & State _____

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

Appointment Title _____ Institution _____ City & State _____

Appointment Title _____ Institution _____ City & State _____

7. LIABILITY CLAIMS

☐ **All applicants are required to submit evidence of malpractice insurance or exemption.**

Please refer to the Financial Responsibility Form following application. This form is the only acceptable documentation for proving malpractice coverage or for providing proof that you are exempt from this requirement. Please **DO NOT** send your actual insurance policy.

☐ 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.

8. CRIMINAL HISTORY

Answers to commonly asked questions can be found on our website at: http://www.floridasnursing.gov/frequently-asked-questions-faqs/

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**.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Failure to disclose information in this section may result in a denial of your application.

If you answered "Yes", you are required to send the following items:

☐ **Self Explanation** describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain document from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Three (3) current (written within the last year) professional **Letters of Recommendation**.

NAME _____

LIVESCAN PRIVACY STATEMENT

☐ I have **been provided and read** the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation. (**Found in Forms Section of this application**). The Board will not receive your Livescan results if you do not affirm the above statement by checking this box.

☐ **Electronic Fingerprinting: (Required for ALL applicants)**

All applicants, including out-of-state and out-of-country applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan device providers that are approved by the Florida Department of Law Enforcement. For a list of approved Livescan vendors, please visit our website at : http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html;

Typically background results submitted by Livescan are received by the Board within 24-72 hours of being processed. The Board of Nursing's ORI number is: ***EDOH4420Z***. **The Board cannot accept hard fingerprint cards or results**. All results must be submitted electronically by the Livescan service provider.

Livescan screenings done by a Florida Police or Sheriff's Department require that you login to the FDLE Civil Applicant Payment System (CAPS) at https://caps.fdle.state.fl.us and pay a fee before results will be released to our office.

Applicants who reside in an area where no Livescan service providers are available or because of state laws prohibiting transmission of fingerprints electronically across state lines should contact a Florida Livescan service provider who has the capability to convert a traditional card (hard card) into an electronic fingerprint card.

Because the Florida Department of Health retains fingerprints on any applicant who is required to undergo a criminal history screening as of January 1, 2013, those prints are retained in the Care Provider Clearinghouse. This Clearinghouse allows for the sharing of criminal history information among specified agencies.

One of the requirements for your Livescan to be retained in the Clearinghouse is a photograph taken by the Livescan service provider at time of fingerprinting. If your Livescan is completed without a photograph, you may have to undergo additional fingerprinting in the future.

- Please include your current mailing address in your request for fingerprint cards.
- **The Board cannot accept hard fingerprint cards or results.**

For Frequently Asked Questions about Livescan see our website at:
http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html;

Livescan service providers that offer hard card conversion to electronic fingerprinting (Livescan):

- Biometric Information Management
  www.bioinfomgt.com
  Call: 614.791.3220
- Ideal Identification, Inc.
  http://www.idealid.net/
  Call: 866.288.6543
- Fieldprint
  https://florida.fieldprint.com/User/
  Call: 877.614.4364
- L-1 Solutions
  www.L1Enrollment.com
  Call: 888.859.4356 or 800.528.1358

NAME _____

9. DISCIPLINE 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. (Attach additional sheets, if necessary)

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

Failure to disclose information in this section may result in a denial of your application.

If you answered "Yes" to any of the questions in this section, you are required to send the following items:

☐ **Self Explanation,** describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint and Final Order**.

☐ Three (3) current (written within the last year) professional **Letters of Recommendation**.

NAME _____

10. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer **"Yes"** to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☐ No Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No"to the question above, skip to question 2.

a. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "Yes", please provide supporting documentation).

2. ☐ Yes ☐ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

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

NAME _____

4. ☐ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?

If you responded "No" to the question above, skip to question 5.

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

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

5. ☐ Yes ☐ No Are you currently listed on the United States Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals and Entities?

6. ☐ Yes ☐ No **If "Yes" to any of the questions 1 through 5 above**, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (**If "Yes", please provide official documentation verifying your enrollment status.**)

11.

Confidential and Exempt from Public Records Disclosure

* This page and the following page 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.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

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.

Board of Nursing
4052 Bald Cypress Way, Bin # C02
Tallahassee, Florida 32399-3252
Phone: (850) 245-4125 Fax: (850) 617-6460
Website: www.floridasnursing.gov

NAME _____

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

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	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?
E.	☐ 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?

If you answered "Yes" to any of the questions in this section , you are required to send the following items:

☐ **Self Explanation,** 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 must be current within the last year.**

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13. ADDITIONAL INFORMATION

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?

Florida Center for Nursing:

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 health care 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

existing nurses.
nurses alone will not resolve he shortage. Efforts must be taken to retain the experiential knowledge of our

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:
http://www.flcenterfornursing.org/Donations/HowyourdonationshelptheFCN.aspx

The Florida Center for Nursing's operating revenues are 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 website or by adding your donation with your application fee.

Do you want to donate to the Florida Center for Nursing? ☐ Yes ☐ No

If you chose to include a donation with your application fee please indicate the amount. $_____

Donations are voluntary and do not impact the processing of your application.Donations made through the Florida Center for Nursing's website are tax deductible.

NAME _____

14. APPLICANT SIGNATURE

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. (Note: Ch 464 and Rule Chapter 64B9 may be obtained via the internet at www.floridasnursing.gov).

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.

Applicant's Signature _____ **Date** _____

This field cannot be typed. You must print out the application and sign it. (MM/DD/YYYY)

RN & ARNP Dual Applicant		ARNP Only Must have current Florida RN License	
Fees Paid to Board		**Fees Paid to Board**	
RN Processing Fee	$50.00		
RN Initial Licensure Fee	$50.00		
Student Loan Forgiveness Fund	$5.00		
Unlicensed Activity Fee	$5.00		
ARNP application fee	$100.00	ARNP application fee	$100.00
Total	**$210.00**	**Total**	**$100.00**
Optional Dispensing Practitioner	$100.00	**Optional** Dispensing Practitioner	$100.00
Additional Fees to be Paid by the Applicant		**Additional Fees to be Paid by the Applicant**	
Live Scan	Paid to Livescan Provider	Live Scan	Paid to Livescan Provider
License Verification	Paid to NURSYS or State of Licensure		

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 board related fees listed 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

Withdrawal and Refund of Applications

If you decide to withdraw your application, you must make the request in writing. The signed 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 $60.00 (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. We are unable to issue refunds directly to credit cards. All refunds will be sent in the form of a check.

Telephone Number: 850-245-4125
Fax Number: 850-617-6460
Web Site: www.floridasnursing.gov
Email:MQA.NursingAppstatus@flhealth.gov

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html;
- Livescan screenings done by a Florida Police or Sheriff's Department require that you login to the FDLE Civil Applicant Payment System (CAPS) at https://caps.fdle.state.fl.us and pay a fee before results will be released to our office.
- Out of State/Country Livescan directions are included in the electronic fingerprinting section of this application.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Nursing is: ***EDOH4420Z***.
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____

Aliases: _____

Date of Birth: _____ (MM/DD/YYYY) Place of Birth: _____

Social Security Number: _____

Citizenship: _____ Race: _____
(W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: _____ (M=Male; F=Female) Weight: _____ Height: _____

Eye Color: _____ Hair Color: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip Code: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Live Scan Vendor.)

You will need to keep this form for your records. Do not send this form to the Board Office.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI (may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice,FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

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.

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: _____

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, 08/14, Rule 64B9-4.002, F.A.C.

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, 08/14, 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.