Important Information for all Applicants

You must have a current Florida RN license to apply for a CNS Upgrade.

For Clinical Nurse Specialist licensure requirements, refer to Sections 464.008, 464.009, and 464.0115 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/lastest-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's license or a U.S. Social Security card.

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

Clinical Nurse Specialist (CNS) 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 Advanced Registered Nurse Practitioner (ARNP). Find the ARNP application on our website at:
http://floridasnursing.gov/applications/dual-enrol-rn-arnp-app.pdf

Choose your specialty type: (Check one only) The fee for this application is $75.00

- ☐ Advanced Diabetes Management
- ☐ Adult Health (Medical Surgical Nursing)
- ☐ Certified Critical Care Nurse Specialist
- ☐ Advanced Certified Hospice and Palliative Nurse
- ☐ Adult Psychiatric & Mental Health
- ☐ Public/Community Health Nursing
- ☐ Gerontological Nursing ☐ Pediatric Nursing
- ☐ Advanced Oncology Clinical Nurse Specialist
- ☐ Child & Adolescent Psychiatric and Mental Health
- ☐ Other _____

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 ☐ 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. Florida RN License Number: _____ **You must have a current Florida RN license to apply for a CNS Upgrade.**

All applicants must have a current RN license that is not expiring within 120 days:

- The CNS certification is an upgrade of a current Florida Registered Nursing License. Therefore, if your Florida RN license due for renewal or will be within 120 days of applying for CNS certification, you must renew your Florida RN license **before** the CNS 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

B. ☐ Yes ☐ No **Are you nationally certified by one of the recognized certifying bodies?** The recognized bodies are: American Nurses Credentialing Center (ANCC), Oncology Nursing Certification Corporation (ONCC), American Association of Critical Care Nurses (AACN), National Board for Certification of Hospice and Palliative Nurses (NBCHPN).

All applicants must submit Proof of National Certification or Affidavit:

☐ Proof 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.

OR

☐ Specialities **where there is no certification** must meet the requirements found on and submit the Affidavit found at the end of the application.

C. 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 CNS 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. ☐ 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 D in this section you must submit a self explanation as to why you are answering "Yes" to this question.

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

POST BASIC CERTIFICATE, GRADUATE, OR POST GRADUATE CLINICAL NURSE SPECIALIST EDUCATION

A. CNS Nursing School Attended: _____

B. Address:

_____ Street address _____ City _____ State _____ Zip Code

C. Program Type: ☐ MSN ☐ Post Masters D. Graduation Date _____ (MM/YYYY)

E. Additional Nursing School Attended: _____

F. Address:

_____ Street address _____ City _____ State _____ Zip Code

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

All applicants must have Official Transcripts and Verification of Successful Completion submitted:

☐ An official transcript sent directly from the school, confirming the degree earned and the date of graduation.

☐ All transcripts should be accompanied with the Verification of Successful Completion form.

5. CRIMINAL HISTORY Answers to commonly asked questions can be found on our website at: http://www.floridasnursing.gov/help-center/#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.

B. ☐ Yes ☐ No Have you **EVER** had any records sealed pursuant to section 943.059, F.S., or other states applicable statute?

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

If you answered "Yes"to either of the questions above 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**.

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6. DISCIPLINARY HISTORY

A. ☐ 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?

B. ☐ Yes ☐ No Have you ever surrendered a license to practice any health care related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?

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

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 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: 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)

Fees Paid to Board

Processing Fee $75.00 *

*** Non-Refundable**

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
PO 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. Processing fees for this application are non-refundable one the application has had the initial review. **Do not stop payment on your cashier's check or money order.** This could result in a “bad check charge” being filed against you.

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

Verification of Successful Completion of a Master's Degree as a Clinical Nurse Specialist (CNS) in a Clinical Speciality Area of CNS Practice

This form is required for all applicants.

Section I. This section is to be completed by the applicant.

Name: _____ _____ _____ _____
Last/Surname 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. This section is to be completed by the program director/representative for the master's level academic program. Please complete and return to the Florida Board of Nursing.

Name of Master's Academic Program: _____

Address: _____ _____ _____ _____
Number & Street City State Zip Code

Clinical Speciality Area: _____

Date Conferred: _____
(Month) (Day) (Year)

Entrance and Completion Dates: From: _____ To: _____
(Month) (Day) (Year) (Month) (Day) (Year)

I certify under penalty of perjury that the documentation regarding the completion of the master's degree in a clinical speciality area of CNS practice for the name applicant is true and correct.

Director' Signature: _____ Date: _____

Title: _____ Telephone Number: _____

OFFICIAL SCHOOL SEAL:

This form is required for all applicants.

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 - CNS
Tallahassee, FL 32399-3252

Name: _____

Social Security Number: _____

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.

Who needs to use this form?

Applicants who hold a master's degree in a specialty area **for which there is no certification** within the clinical nurse specialist role and specialty and who can provide proof of having completed 1,000 hours of clinical experience in the clinical specialty for which he or she is academically prepared, with a minimum of 500 hours of clinical practice after graduation.

STATE OF FLORIDA)
)
_____County)

AFFIDAVIT

BEFORE ME, the undersigned authority, personally appeared _____, who, after being duly sworn, deposes and states as follows:

1. I meet the qualifications for licensure as a Clinical Nurse Specialist under Florida Statutes 464.0115.

2. My clinical master's degree is in the specialty area of _____, for which there is no national certification exam available within the clinical nurse specialist role.

3. I have at least 1000 hours of clinical experience in my area of clinical specialty and at least 500 of these hours have been completed post graduation.

FURTHER AFFIANT SAYETH NAUGHT.

_____
Signature of Applicant (to be signed before the notary)

SWORN TO AND SUBSCRIBED before me this _____ day of _____, _____ by

_____who is personally known to me or has provided identification in the form of

_____.

_____
NOTARY PUBLIC

_____
(Typed name of notary public)

Commission number_____