Advanced Practice Registered Nurse Application

Board of Nursing
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasnursing.gov
Email: Mqa.Nursingappstatus@flhealth.gov
Phone: (850) 245-4125
Fax: (850) 617-6460

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

Florida HEALTH
Medical Quality Assurance

Advanced Practice Registered Nurse Information

Refer to section (s.) 464.012, Florida Statutes (F.S.), and Rule 64B9-4, Florida Administrative Code (F.A.C.) **for Advanced Practice Registered Nurse (APRN) licensure information.**

Dispensing is defined as selling medicinal drugs to patients in the office. Writing prescriptions or providing complimentary samples is not dispensing. If you wish to be a dispensing practitioner, submit the required fees and the **"Dispensing Application for Advanced Practice Registered Nurse (APRN)" form** https://floridasnursing.gov/applications/disp-aprn-app.pdf.

To request a name change, you must submit proper documentation. Acceptable forms of 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.

Advanced Practice Registered Nurse Application

Board of Nursing
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: 850-617-6460
Email: mqa.nursingappstatus@flhealth.gov

Do Not Write in this Space For Revenue Receipting Only

In order to qualify for an APRN license, you must hold an active Registered Nurse license in any U.S. jurisdiction.

Select one APRN (1711) **specialty type:** **$110.00**

☐ Certified Nurse Practitioner ☐ Certified Nurse Midwife

☐ Psychiatric Nurse Practitioner ☐ Clinical Nurse Specialist

☐ Certified Registered Nurse Anesthetist

Nationally Certified in (Ex. Adult, Family, OB/GYN, Pediatric):

_____

☐ **Dispensing** (Optional) + **$100.00** (see page 3)

Total fee of $110.00 includes the following:

Application Fee (non-refundable)	$50.00
Licensure Fee	$50.00
Unlicensed Activity Fee	$5.00
Student Loan Forgiveness Fund	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

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

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

Street/P.O. Box Apt. No. City

State ZIP Country Home/Cell Telephone (Input without dashes)

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

Street Apt. No. City

State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email 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. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

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, § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. 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 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 C-02
Tallahassee, FL 32399-3252

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. List the month and year you legally began to practice as an APRN. ☐ N/A _____ MM/YYYY

C. Do you hold, or have you ever held a license to practice nursing or any other health-related license(s)?
☐ Yes ☐ No

D. List all health-related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

The board requires verification of licensure from your original state of licensure (exam state) and from a state where you have a current active license. Only one verification is required if your original state is current and active. **Office staff will attempt to complete verifications online.** If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification.

E. In which state did you take the Registered Nurse examination? _____

F. Rule 64B9-4.002(2), F.A.C., provides the professional or national nursing specialty boards recognized by the board. You can view the rule at www.flrules.org/gateway/Organization.asp?OrgNo=64B9.

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

If you responded "Yes," complete the following:

Certifying Board(s)	Original Certification Date (MM/DD/YYYY)

☐ **All applicants must submit Proof of National Certification.** This proof can be sent directly from the national certifying body or the applicant can submit a copy of current certification/recertification card. Exam results are not considered proof of national certification.

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

Name: _____

5. EDUCATION HISTORY

A. List the basic nursing school you attended.

School Name	Graduation Date (MM/DD/YYYY)
School Address (Street, City, State, ZIP, Country)	**Degree Awarded**
	☐ **ADN** ☐ **BSN**

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

_____

Nurse practitioners and **certified nurse midwives** who graduated on or after October 1, 1998 **must have** graduated from a master's degree or post-master's certification program.

Applicants certified as a **registered nurse anesthetist** who graduated on or after October 1, 2001 **must have** graduated from a master's degree program.

Certified clinical nurse specialists graduating on or after July 1, 2007 **must have** graduated from a master's degree program.

Applicants who graduated prior to the application date(s) are exempt from this requirement.

Graduates from either **certificate programs or currently closed programs** must submit supporting documentation that demonstrates program compliance with board guidelines. This includes:

☐ A copy of the philosophy and purpose of the program

☐ Course objectives and content (syllabus, catalog, or brochures)

☐ Faculty credentials including nurse practitioners on staff

C. List the postbasic education program(s) attended.

School Name	Graduation Date (MM/DD/YYYY)
School Address (Street, City, State, ZIP, Country)	**Degree Awarded**
	☐ **MSN** ☐ **DNP** ☐ **Post Masters**

6. FACULTY APPOINTMENTS

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

Name of Institution/Address	Title of Appointment

B. List any responsibility you have had for graduate education within the last ten years or enter N/A.

Name of Institution/Address	Title of Appointment

Name: _____

This information is exempt from public records disclosure

7. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

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

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

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status

Name: _____

8. DISCIPLINE HISTORY

A. 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? ☐ Yes ☐ No

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

C. Have you ever had any final disciplinary action taken against you by the licensing agency in this state or any jurisdiction? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Agency	Action Date (MM/DD/YYYY)	Description of Violation	Description of Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

D. 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?
☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Institution	Action Date (MM/DD/YYYY)	Description of Violation	Description of Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

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

If you responded "Yes," complete the following:

Name of Specialty Board	Action Date (MM/DD/YYYY)	Description of Violation	Description of Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

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

If you responded "Yes" to any questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

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

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

Name: _____

9. CRIMINAL HISTORY

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any 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 (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

B. Have you ever had any records sealed pursuant to s. 943.059, F.S., or other state's applicable statute?
☐ Yes ☐ No

If you responded "Yes" in this section, complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes," you must provide the following:

☐ **Self-Explanation**, describing in detail the circumstances surrounding each offense; including date, 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 documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

☐ Three 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 convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

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

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

   a. 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? ☐ Yes ☐ No

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

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

   d. 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," provide supporting documentation). ☐ Yes ☐ No

2. 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)? ☐ Yes ☐ No

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

   a. 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? ☐ Yes ☐ No

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

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

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

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

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

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

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

Name: _____

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

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **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.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documentation for sections 7 and 8 must be sent to the board office at MQA.Nursing@flhealth.gov or mailed to:

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

Documentation for sections 9 and 10 must be sent to MQA.BackgroundScreen@flhealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

11. LIABILITY CLAIMS

All applicants are required to submit evidence of malpractice insurance or exemption. Refer to the **"Financial Responsibility" Form** following the application. This form is the **only acceptable documentation** for proving malpractice coverage or for providing proof that you are exempt from this requirement. **Do not** sent your actual insurance policy.

Within the last ten years have you had any professional liability claims in excess of $5,000? ☐ Yes ☐ No

If you responded "Yes," provide the following:

A self-explanation that includes the nature of the claim, incident date, county, judicial case number, settlement date, settlement amount, and the statutory explanation of why the settlement occurred.

Documentation for this sections must be sent to the board office at MQA.Nursing@flhealth.gov or mailed to:

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

Name: _____

12. 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 the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

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

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: http://www.flhealthsource.gov/background-screening/.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board'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 performed 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 your results will be released to our office.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. You will be notified when your retention date is approaching and will be provided with instructions on how to retain your fingerprints to avoid having to submit a new background screening

Applicants needing hard fingerprint cards can request them via email at MQA.BackgroundScreen@flhealth.gov. Request must include the current mailing address you want the cards mailed to. To find providers who offer this service go to http://www.flhealthsource.gov/bgs-providers. Click on **"Out of State/International"** section of the map.

Name: _____

13. 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 the 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 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.

The Florida Center for Nursing's 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 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.

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 s. 456.067, 775.083, F.S.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations or any kind.

I further state that I have read and understand ch. 464, F.S., and Rule ch. 64B9, F.A.C., as they pertain to the practice of nursing (Note: A current copy of ch. 464 and rule ch. 64B9 may be obtained online at http://www.floridasnursing.gov).

Florida law requires me 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 renewal including continuing education.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____

You may print this application and sign it or sign digitally. MM/DD/YYYY

This form is required for all applicants.

Board *of* Nursing
Financial Responsibility

Name: _____

Florida License Number (if applicable): _____

The Financial Responsibility options are divided into two categories: coverage and exemptions.
Choose only ONE option that best describes your situation, unless you choose **option 3** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S., or a risk retention group under s. 627.942, F.S.

☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined by ch. 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 APRN as beneficiary.

☐ 3. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category on the following page.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILTY COVERAGE

☐ 1. I practice medicine 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 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 Practice Registered Nurse Program and/or I am not yet practicing in Florida.

Section 456.067, F.S., Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her 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 in s. 775.082, s.775.083, or s. 775.08, F.S.

Applicant Signature _____ Date _____
MM/DD/YYYY

You may print this application and sign it or sign digitally.

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

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL REOCRDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREEING 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 to be employed, licensed, work under contract, or 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 Person 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 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 your 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, disclosure 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 a 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 additional information 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.

Board *of* Nursing
Electronic Fingerprinting

Take this form with you to the Livescan service provider. 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 a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: http://www.flhealthsource.gov/background-screening/.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- 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: _____ SSN#: _____

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

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

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

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

Sex: - _____
(M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

Office staff will attempt to complete verifications online. If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification.

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

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

Board *of* Nursing License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

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

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

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?
* Date of issuance/expiration
* Licensure method (examination, grandfathering, reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.