Florida HEALTH

Board of Nursing Mobile Opportunity by Interstate Licensure Endorsement (MOBILE)

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: FLHealthSource.gov
Phone: 850-488-0595

DH-MQA-5102, 6/2026, Rule 64B9-3.008 and 64B9-15.0035, F.A.C.

Qualifications for Licensure

Expedite your application by applying online at FLHealthSource.gov.

If you do not meet all the qualifications listed below, you may qualify for licensure by applying with the "Nursing Licensure by Examination Application," **even if you have already taken the NCLEX for the profession.**

1. Must hold an active, unencumbered license issued by another state, the District of Columbia, or a territory of the United States in a profession with a similar scope of practice, determined by the board or the department, as applicable. The term "scope of practice" means the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license issued in this state.

2. Must have obtained a passing score on a national licensure examination or hold a national certification recognized by the board, or the department if there is no board, as applicable to the profession for which the applicant is seeking licensure in this state;

   OR

   An applicant for a profession that does not require a national examination or national certification is eligible for licensure if the applicable board, or the department if there is no board, determines that the jurisdiction in which the applicant currently holds an active, unencumbered license meets established minimum education requirements and, if applicable, examination, work experience, and clinical supervision requirements are substantially similar to the requirements for licensure in that profession in this state.

3. **Must have actively practiced** the profession for which the applicant is applying **for at least two years during the four-year period immediately** preceding the date of submission of this application.

4. **Must not be**, at the time of submission of the application, **the subject of a disciplinary proceeding** in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reason related to the practice of the profession for which the applicant is applying.

5. **Must not have had disciplinary action** taken against you **in the five years immediately preceding** the date of submission of the application.

6. Advanced Practice Registered Nurses must meet the financial responsibility requirements of section 456.048, Florida Statutes, and Chapter 464, Florida Statutes.

7. Refer to section 456.0145(2)(c), Florida Statutes, for licensure **ineligibility criteria**.

8. CNAs, LPNs, RNs, and APRNs require Livescan screening per Chapter 464, Florida Statutes.

9. Apply online at FLHealthSource.gov or submit your application, any applicable fees, and any supplemental documentation to the Department of Health at the address listed on the application below.

10. **Practitioner Profiling:** Section 456.0391, Florida Statutes, requires Advanced Practice Registered Nurses to furnish specific information for publication on the Department of Health's website.

Florida is a member of the Nurse Licensure Compact (NLC). The NLC allows a registered nurse or licensed practical nurse licensed in a Compact State to practice across state lines in another Compact State without having to obtain a license in the other state unless the nurse moves and declares the new Compact State as their new primary state of residence. It is important to understand that the NLC requires nurses to adhere to the nursing practice laws and rules of the state in which they practice under their Compact license. The Compact does not include Advanced Practice Registered Nurses. If a nurse moves from one state to another and establishes residency, the nurse must apply for licensure in that state. Visit the National Council of State Boards of Nursing (NCSBN) website NCSBN.org/Nurse-Licensure-Compact.htm for a list of states that have implemented the Compact.

All LPN and RN applications will be screened for eligibility for a multistate license under the compact and a multistate license will be issued to all eligible applicants. Applicants not eligible for multistate licensure, but otherwise eligible for licensure in Florida will be issued a single-state license and be provided with an explanation of the criteria not met for multistate licensure. Additional information about the compact is available at NurseCompact.com.

Name: _____

Board *of* Nursing
Nurse Licensure Compact (NLC)

This page to be completed by LPN/RN applicants ONLY

Requirements that must be met to qualify for a LPN/RN multistate license from Florida:

Florida must be the Primary State of Residence*
Must have passed the NCLEX or the SBTPE
Florida's requirements for initial licensure must be met
The status of **all** nursing licenses (CNA, LPN, RN, and APRN) must be clear and unencumbered in all jurisdictions**
Must not have **any** misdemeanor conviction*** related to the practice of nursing, **regardless of adjudication**
Must not have **any** felony conviction***, **regardless of adjudication**
Must not be enrolled with the Intervention Project for Nurses (IPN) or any other treatment program for impaired practitioners
Must have a U.S. Social Security number
Must have completed an LPN or RN program, PNEQ **does not** qualify
Applicants Educated Outside the U.S. or NCSBN Jurisdictions Only
Education must be evaluated by an independent credentials review agency
Education completed in a language other than English will require an English competency examination

Terminology:

***Primary state of residence** is defined by the Compact as the "person's declared fixed permanent and principal home for legal purposes; domicile."

****Encumbrance** means "revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing, imposed by a licensing board."

*****Conviction** is defined as being "convicted or found guilty, or has entered into an agreed disposition other than a disposition that results in nolle prosequi, for an offense under applicable state or federal criminal law."

Proof of primary residence may include but is not limited to:

Driver license with a home address
Voter registration card displaying a home address
Federal income tax return declaring the primary state of residence
W2 from U.S. Government or any bureau, division, or agency thereof indicating the declared state of residence

NURSE LICENSURE COMPACT (NLC)

A. Do you declare Florida to be your primary state of residence for multistate licensure and are you providing a Florida address? ☐ Yes ☐ No

If you **do not have a current Florida mailing address, and wish to have a multistate license, you must provide** one of the documents listed above. If Florida is not your primary state of residence, you are **not eligible** for a Florida multistate license and your application will be processed for a single state license.

B. Do you hold an active NLC multistate license in another state? ☐ Yes ☐ No

A nurse may only hold one multistate license. If your declared primary state of residence is another Compact state and you are not changing your primary residence to Florida, you are not eligible for a multistate license in Florida and should **not submit this application,** as your NLC license allows you to practice in Florida.

Board *of* Nursing
Board-Approved Education Evaluation Providers

Only LPN and RN applicants who were **educated outside the U.S., or Graduates from U.S. Territories** whose regulatory nursing board is **not a member of the National Council of State Boards of Nursing** (NCSBN) are required to have a **full education credentials review** by a Florida board-approved credentialing agency, or provide proof from your original licensing jurisdiction that an approved evaluation has been completed.

An original copy of the credentials report must be sent electronically to the board directly from the agency. The board does not accept paper copies. Applicants are responsible for paying all fees the agency charges for these services.

Credentials reports received from a credentialing agency not listed below will not be accepted.

Board-Approved Education Evaluation Providers

Ashland Educational Services
Foreign Credentials Evaluation Agency
15192 S.W. 137 Street, Suite 10
Miami, FL 33196, USA
Phone: 786-457-4608
Email: Admin@AshlandEducationalServices.com
Web: AshlandEducationalServices.com/

Educational Records Evaluation Service, Inc.
2480 Hilborn Road, Suite 106
Fairfield, CA 94534, USA
Phone: 707-759-2866
Email: Edu@ERES.com
Web: ERES.com

SpanTran: The Evaluation Company
Phone: 305-749-0333
Email: Intake@SpanTran.com
Web: SpanTran.com
Houston Office -
2400 Augusta Drive, Suite 451
Houston, TX 77057, USA
Miami Office -
2655 Le Jeune Rd, Suite 602
Coral Gables, FL 33134, USA
New York Office -
450 Fashion Ave, Suite 1004
New York, NY 10123, USA

Commission on Graduates of
Foreign Nursing Schools
3600 Market Street, Suite 400
Philadelphia, PA 19104-2641, USA
Applicant Inquiries: 215-349-8767
Customer Service Fax: 215-622-0425
Automated Phone System (to check status):
215-599-6200
Email: Info@CGFNS.org
Web: CGFNS.org

International Education Evaluations, LLC
7900 Matthews-Mint Hill Road, Suite 300
Charlotte, NC 28227, USA
Phone: 615-337-1611
Web: MyIEE.org

Josef Silny & Associates, Inc.
International Education Consultants
7101 S.W. 102 Avenue
Miami, FL 33173, USA
Phone: 305-273-1338
Fax: 305-273-1338
Email: Info@JSilny.org
Web: JSilny.org

Board *of* Nursing
Approved English Competency Examinations / Visa Information

Only LPN and RN applicants who were **educated outside the U.S., or Graduates from U.S. Territories** whose regulatory nursing board is **not a member of the NCSBN** are required to provide proof of English competency if textbooks and instruction were not completed in English, or provide proof from their original jurisdiction that valid English competency has been completed.

Approved English Competency Examinations

IELTS Cambridge/IELTS International
100 East Corson Street, Suite 200
Pasadena, CA 91103, USA
Phone: 626-564-2954
Fax: 626-564-2981
Email: IELTS@CEII.org
Web: IELTS.org

Michigan Language Assessment
Argus 1 Building
535 West William Street, Suite 310
Ann Arbor, MI 48104-4978, USA
Phone: 734-615-9629
Fax: 734-763-0369
Web: MichiganAssessment.org/Michigan-Tests/Met

Occupational English Test
(OET)
Post Office Box 16136
Collins St. West VIC 8007
Australia
Web: OccupationalEnglishTest.org

PTE Academic
English Language Learning
221 River Street
Hoboken, NJ 07030, USA
Phone: 903-474-5972
Applicant Inquiries: PearsonPTE.com

TOEFL Services
Educational Testing Service
Post Office Box 6151
Princeton, NJ 08541-61511, USA
Phone: 609-771-7100
Fax: 609-734-1560
Email: TOEFL@ETS.org
Web: ETS.org

Applicants with questions regarding visas or work permits should contact:

Bureau of Immigration and Customs Enforcement
4255 “I” Street N.W.
Washington D.C. 20536, USA
Phone: 800-375-5283
Web: USCIS.gov/Portal/Site/USCIS

For visa screenings contact:

Commission on Graduates of Foreign Nursing Schools (CGFNS)
3600 Market Street
Philadelphia, PA 19104, USA
Phone: 215-349-8767
Web: CGFNS.org

Josef Silny & Associates, Inc.
International Education Consultants
7101 S.W. 102 Avenue
Miami, FL 33173, USA
Phone: 305-273-1338
Web: JSilny.org

Board of Nursing
Mobile Opportunity by Interstate Licensure Endorsement (MOBILE)

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330

Do Not Write in this Space
For Revenue Receipting Only

Select application type:

- ☐ Certified Nursing Assistant (CNA) 4401- **No Fees**
- ☐ Licensed Practical Nurse (LPN) 1702- **$110.00**
- ☐ Registered Nurse (RN) 1701- **$110.00**
- ☐ Advanced Practice Registered Nurse (APRN) 1711- **$110.00**

Total fee of $110.00 includes the following:

Processing Fee	$50.00
Initial Licensure Fee	$50.00
Student Loan Forgiveness Fund	$5.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $60.00 (Initial Licensure Fee, Student Loan Forgiveness Fund, and Unlicensed Activity Fee) refund. 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

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

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

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 of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

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 sections 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 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 SSA.gov or by calling 800-772-1213.

3. APPLICANT BACKGROUND

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

_____

B. Do you hold an active, unencumbered license issued by another state, the District of Columbia, or a territory of the United States in a profession with a similar scope of practice as defined in section 456.0145(2)(a)2., Florida Statutes, in the profession for which you are applying? ☐ Yes ☐ No

C. List all health-related licenses (active, inactive, or lapsed). Attach additional sheets if necessary.

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

☐ 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 from your state. License verifications must be received directly from the licensing authority. A copy of your license will not be accepted in lieu of official verification from the licensing agency.

D. Have you actively practiced the profession for which you are applying for at least two years during the four-year period immediately preceding the date of submission of the application? ☐ Yes ☐ No

Note: If you responded "No" to question D, you may be ineligible for licensure under this method per section 456.0145(2)(a)4., Florida Statutes.

E. Have you obtained a passing score on a national licensure examination or do you hold a national certification recognized by the board for the profession for which you are applying? ☐ Yes ☐ No

If "Yes," complete one of the following:

Licensure Examination	Date of Examination (MM/DD/YYYY)

OR

National Certification	Date of Certification (MM/DD/YYYY)

☐ Board staff will obtain national scores from the examination vendor, if available. Applicants must submit proof of national certification.

F. Does your profession require a national licensure examination or national certification? ☐ Yes ☐ No

If "No," submit evidence that you meet the established minimum education requirements and, if applicable, examination, work experience, and clinical supervision requirements that are substantially similar to the requirements for licensure in your profession in Florida.

4. AVAILABILITY FOR 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

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Name: _____

This information is exempt from public records disclosure.

5. 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.

For LPN/RN Applicants ONLY:

Are you a current participant in an alternative to discipline program (i.e. Intervention Project for Nurses (IPN))?

☐ Yes ☐ No

6. DISCIPLINE HISTORY

A. Are you currently the subject of a disciplinary proceeding in a jurisdiction in which you hold a license or by the United States Department of Defense for reasons related to the practice of the profession for which you are applying? ☐ Yes ☐ No

B. Have you ever had any 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? ☐ Yes ☐ No

C. **If you responded "Yes" to question B,** have you had disciplinary action taken against any license by the licensing authority in any state, jurisdiction, or country within the last five years? ☐ Yes ☐ No ☐ N/A

D. Do you have a complaint, an allegation, or investigation pending before a licensing entity in any U.S. jurisdiction or territory? ☐ Yes ☐ No

E. Have you ever had a license to practice a health care profession revoked or suspended by any U.S. jurisdiction or territory or voluntarily surrendered any such license in lieu of having disciplinary action taken against the license? ☐ Yes ☐ No

Note: If you responded "Yes" to any question in this section, you may be ineligible for licensure under this method per section 456.0145(2), Florida Statutes.

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

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

If you responded "Yes" to any of the 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, Final Order, and proof of compliance of any obligations, if applicable**.

F. Have you been reported to the National Practitioner Data Bank (NPDB)? ☐ Yes ☐ No

G. **If you responded "Yes" to question F,** have you successfully appealed to have your name removed from the data bank? ☐ Yes ☐ No ☐ N/A

Note: A person is ineligible for licensure under this method if they have been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have their name removed from the data bank per section 456.0145(2)(c), Florida Statutes.

Licensure may be permissible if the reported adverse action was a result of conduct that would not constitute a violation of any Florida law or rule. Licensure in this case may be subject to conditions such as restrictions or probation per section 456.0145(2)(c), Florida Statutes.

Staff will complete a NPDB query. For more information, visit the National Practitioner Data Bank at NPDB.HRSA.gov/Ext/SelfQuery/SQHome.jsp.

7. CRIMINAL HISTORY

*For the question below, 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.*

*Pursuant to section 943.0585(6)(b), Florida Statutes, and section 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.*

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? ☐ 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" in this section, you must provide the following:

☐ **A written 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 documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

8. 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 time frames as established in section 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter 409, Florida Statutes (relating to social and economic assistance), Chapter 817, Florida Statutes (relating to fraudulent practices), Chapter 893, Florida Statutes (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 10 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 section 893.13(6)(a), Florida Statutes)? ☐ Yes ☐ No

c. If "Yes" to 1, for the felonies of the third degree under section 893.13(6)(a), Florida Statutes, 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? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) 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 section 409.913, Florida Statutes? ☐ 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. If "Yes" to 4, 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

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 self-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** that includes court dispositions, agency orders, and completion of sentence documents, if applicable.

Name: _____

9. 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.**

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 FLHealthSource.gov/Background-Screening/.

Typically, background results submitted by Livescan are received by the board within 24-72 hours of being processed. The ORI number for **CNAs** is **EDOH0380Z**. The ORI number for **LPNs, RNs, and APRNs** is **EDOH4420Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

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. Licensees will be notified when their retention date is approaching and will be provided instructions on how to retain their fingerprints to avoid having to submit a new background screening.

10. 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 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, donate by adding your donation with your application fee.

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

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

Donations are voluntary and do not impact the licensing process. Donations made through the Florida Center for Nursing's website are tax deductible.

Name: _____

11. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I have carefully read the questions in the foregoing application and have answered them completely. These statements are true and correct. I recognize that providing false information may result in denial of certification/licensure, disciplinary action against my certification/license, or criminal penalties pursuant to section 456.067, Florida Statutes. I have read Chapter 456, Florida Statutes, the practice act governing the profession for which I am applying, and the Florida Administrative Code chapter governing the profession for which I am applying.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Department of Health information which is material to my application for licensure.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my certification/license to practice the profession for which I am applying in the state of Florida. 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.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the Department of Health.

Applicant Signature _____ Date _____

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

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS 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 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 section 943.056, Florida Statutes, 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 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 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.

Department of Health
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 FLHealthSource.gov/Background-Screening.
- Livescan screenings done by Florida Police or Sheriff's Departments require that you login into the FDLE Civil Applicant Payment System (CAPS) at CAPS.FDLE.State.FL.US and pay a fee before results will be released to our office.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the Department of Health.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider applicable board offices will not receive your background screening results.
- The ORI number for **CNAs** is **EDOH0380Z**. The ORI number for **LPNs, RNs, and APRNs** is **EDOH4420Z**.
- You must provide demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- 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: _____ Date of Birth: _____

MM/DD/YYYY

Citizenship: _____ Place of Birth: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

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)

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

Keep this form for your records.

Complete forms must be sent to the board office via email at MQA.NursingAppStatus@FLHealth.gov, or mailed to:

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

Board *of* Nursing
Declaration of Primary State of Residence

Florida is a member of the Nurse Licensure Compact which allows Registered Nurses (RN) and Licensed Practical Nurses (LPN) the privilege to practice in other participating Compact states. As part of this process, all applicants for licensure must declare their primary state of residence and all states where you are practicing or intend to practice.

This form serves as a supporting document for initial RN/LPN Nursing licensure applications or "Multistate License Upgrade Application" only.

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

U.S. Social Security Number: _____ Florida License #: _____

Mailing Address:

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

_____ _____ _____
State ZIP Home/Cell Telephone

Are you currently active-duty military? ☐ Yes ☐ No

I declare my primary state of residence is: _____

I intend to primarily practice in the state of: _____

I intend to practice in the state(s) of: _____

_____

Signature: _____ Date: _____
MM/DD/YYYY

Advanced Practice Registered Nurses ONLY

Board *of* Nursing
Financial Responsibility

Name: _____

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 section 624.09, Florida Statutes, from a surplus lines insurer as defined under section 626.914(2), Florida Statutes, from a risk retention group as defined under section 627.942, Florida Statutes, from the Joint Underwriting Association established under section 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in section 627.357, Florida Statutes, or a risk retention group under section 627.942, Florida Statutes.

☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined by Chapter 675, Florida Statutes, 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 below).***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY 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 section 456.015, Florida Statutes, 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, Florida Statutes: Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to section 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the Department of Health, 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 of Health, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in section 775.082, section 775.083, or section 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

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

Advanced Practice Registered Nurses ONLY

Department of Health
Practitioner Profile

Name: _____

This form is only for the professions that require a practitioner profile, listed below. This form must be submitted with your application. Sections 456.039 and 456.0391, Florida Statutes, requires practitioners to furnish specific information for publication on the Department of Health's website.

Medical Doctor (Chapter 458)	Chiropractic Physician (Chapter 460)	Advanced Practice Registered Nurse (Chapter 464)
Osteopathic Physician (Chapter 459)	Podiatric Physician (Chapter 461)	

1. BACKGROUND / EDUCATION AND TRAINING

A. List the year you legally began to practice your profession. Year: _____ YYYY

B. List in chronological order all schools or training programs attended, including graduate education, whether completed or not. Attach a separate sheet if necessary.

School / Training Program Name	School Address	Dates of Attendance: From-To (MM/DD/YYYY)	Date Degree Received (MM/DD/YYYY)
		to	
		to	
		to	
		to	

C. List in chronological order all professional and postgraduate training attended. List all programs you began, whether or not you completed or received credit for the training.

Program Name / Address	Specialty Area	Dates of Attendance: From-To (MM/DD/YYYY)	Credit Received?
		to	☐ Y ☐ N
		to	☐ Y ☐ N
		to	☐ Y ☐ N

D. Are you certified by any specialty board recognized by the Florida board that regulates the profession you are applying for? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Board Name	Certification/Specialty/Subspecialty	Date of Certification (MM/YYYY)

2. ACADEMIC FACULTY APPOINTMENTS

A. Do you currently hold a faculty appointment at an accredited medical school? ☐ Yes ☐ No

B. Have you had the responsibility for graduate education within the last 10 years? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Institution	City/State	Title of Appointment

Name: _____

3. STAFF PRIVILEGES *(Not required for APRNs)*

A. Do you currently hold staff privileges in any hospital, health institution, clinic, or medical facility? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility	City/State	Type of Privileges	From-To (MM/DD/YYYY)
			to
			to

B. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility	Address	From-To (MM/DD/YYYY)	Under Appeal?
		to	☐ Y ☐ N
		to	☐ Y ☐ N

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

☐ **A written self-explanation** on a separate sheet describing in detail the circumstances.

☐ **Supporting documents** from the applicable entity.

4. DISCIPLINE HISTORY

A. Within the previous 10 years, have you ever had any final disciplinary action taken against you by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Chiropractic Association, national nursing specialty board recognized by the Board of Nursing, or other similar national organization? ☐ Yes ☐ No

B. Within the previous 10 years, have you ever had any final disciplinary action taken against you by the licensing agency in this state or any jurisdiction? ☐ Yes ☐ No

C. Within the previous 10 years, 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, nursing home, or ambulatory surgical center in this state or any jurisdiction? ☐ Yes ☐ No

D. Within the previous 10 years, have you ever been asked to or allowed to resign from or had any staff privileges restricted or not renewed by any medical health-related institution in lieu of facing disciplinary action or during any pending investigation into your practice? ☐ Yes ☐ No

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

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

If you responded "Yes" to any of the 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**.

Name: _____

5. LIABILITY CLAIM HISTORY *(Allopathic and Osteopathic Physicians Only)*

Within the last 10 years have you had any liability claims or actions for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000? ☐ Yes ☐ No

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

☐ **A written self-explanation** listing your involvement in each case

☐ **Completed Exhibit 1 form** for each case (found at the appropriate link below)
Allopathic Physicians: FLBoardofMedicine.gov/Forms/Exhibit-I-Form.pdf
Osteopathic Physicians: FloridasOsteopathicMedicine.gov/Forms/Exhibit-I-Form.pdf

☐ **A copy of the complaint and disposition for each case**

☐ **For judgements when the incident(s) of malpractice occurred after November 2, 2004, the entire case record must be submitted in electronic format** (either PDF or TIFF), preferably on a DVD (do not send originals). The record must include:

- Initial and/or amended complaint
- Trial transcripts
- Evidentiary exhibits
- Final judgement

6. LIABILITY CLAIM HISTORY *(Podiatric Physicians Only)*

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? ☐ Yes ☐ No

☐ **If you responded "Yes," complete the Exhibit 1 form** for each case (found at FloridasPodiatricMedicine.gov/Forms/Form_-_Exhibit_I.pdf)

2. PRACTITIONER SIGNATURE

I, the undersigned, state that I am the person referred to in this Florida Practitioner Profile. I have carefully read the profiling questions and have answered them completely. These statements are true and correct.

Applicant Signature _____ Date _____
MM/DD/YYYY