GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

APPLICATION FOR LICENSURE BY ENDORSEMENT
BOARD OF NURSING

BOARD OF NURSING
REGISTERED NURSE * LICENSED PRACTICAL NURSE

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for **disciplinary action and could be cause for criminal prosecution pursuant to *DC Code 22-2514*. If you have any questions, call HPLA Customer Service at 1-877-672-2174 Monday through Friday, 8:30 AM to 4:30 PM EST.**

Please Note: Please refer to application instructions before completing this form.

SECTION 1A. LICENSURE TYPE & FEES

Please check one: ☐ **LPN** ☐ **RN**

☐ Licensure by Endorsement $230.00

☐ **CRIMINAL BACKGROUND CHECK:** For payment and to schedule an appointment (Call **1-877-783-4787** or www.L1enrollment.com)
All applicants are required to undergo a Criminal Background Check

LICENSURE EXPIRATION: All licenses **expire June 30th**
RNs even numbered year
LPNs odd numbered year

Make check or money order payable to: DC Treasurer

SECTION 2A. APPLICANT INFORMATION

Note: LEGAL NAME: ***(Do not use any initials unless they are a part of your name)***

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

___/_____/____ _____ - _____ - _____ *
Date of Birth **Social Security Number** **GENDER:** ☐ **MALE** ☐ **FEMALE**

***All Applicants must provide a Social Security Number. If you are a foreign graduate and do not have a SSN or are waiting for one to be issued, you must complete the SSN affidavit form and submit it with your application. Your license will not be renewed without a valid SSN. You can download the affidavit form by clicking here or printing a copy at** www.hpla.doh.dc.gov

SECTION 2B. OTHER NAMES USED: (Please print clearly)

Enter your legal name exactly as it should appear on the license. If your name on this application is different from the name on your supporting documentation provide a copy of a legal name change document. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders and spouse's death certificate.

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____
Place of Birth : State/Providence/Territory **Country if not USA**

SECTION 2C: RACE & ETHNICITY DESIGNATION:

☐ **American Indian/Alaskan Native** ☐ **Asian/South Asian** ☐ **Black or African American**

☐ **Caucasian/White** ☐ **Hispanic or Latino**

☐ **Other** _____ ☐ **Native Hawaiian or other Pacific Islander**

LANGUAGE(S) SPOKEN:

Language(s) spoken other than English:

☐ **Spanish** ☐ **French**
☐ **German** ☐ **Arabic**
☐ **Other** _____

SECTION 3A. PREFERRED MAILING ADDRESS

APPLICATION FOR LICENSURE BY ENDORSEMENT

Note: A P.O. BOX MAY NOT BE USED FOR AN ADDRESS. PLEASE PROVIDE A STREET ADDRESS.

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☐ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 3B. HOME /BUSINESS ADDRESS

☐ **Home Address or** ☐ **DC Local/Mailing Address**

ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **PHONE NUMBER: (____) _____ - _____** **FAX: (_____) _____ - _____**

You are statutorily required to notify the DC Board of Nursing in writing of an address change within 30 days. Failure to do may result in your not receiving your license, renewal notice or other official notices and can result in a disciplinary action or a fine.

EMAIL ADDRESS (REQUIRED) : _____ **CELL PHONE:** _____

☐ **Business Address**

ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **PHONE NUMBER: (____) _____ - _____** **FAX: (_____) _____ - _____**

EMAIL ADDRESS: _____ **CELL PHONE:** _____

SECTION 3C. NURSING SCHOOLS ATTENDED

List all nursing schools that you have attended beginning with the most recent at the top.

School Name, City, State, Country	Date of Graduation mm/yyyy	Degree/Certificate

SECTION 3D. PROFESSIONAL LICENSURE IN OTHER JURISDICTIONS

MANDATORY FIELD	JURISDICTION	ACTIVE/ NOT ACTIVE	LICENSE NUMBER
Original licensure			
Current license (if license in original jurisdiction is not active)			

IMPORTANT CONTACT INFORMATION

District of Columbia Health Professional Licensing Administration
Attention: Board of Nursing
899 North Capitol Street, N.E., 2nd Floor
Washington, D.C. 20002

Check Application Status: **www.hpla.doh.dc.gov**
HRLA Customer Service:1-877-672-2174/**www.hpla.doh.dc.gov**
Criminal Background Check (CBC) Unit Email: **doh.cbcu@dc.gov**
Board Email: **hplacomments@dc.gov**

APPLICATION FOR LICENSURE BY ENDORSEMENT

SECTION 4. SUPPORTING DOCUMENTS REQUIRED

Your application along with all required supporting documents must be mailed in the same package to the Board office. Please mail in a 9X12 envelope and do not staple or fold application.

Please indicate the supporting documents you have included with this package. Keep a photocopy.

☐ **Passport-Type Photos - Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.**

☐ **Copy of legal document supporting name change (if applicable). Acceptable documents are marriage certificates, divorce decree, court orders or spouse's death certificate.**

☐ **SSN Affidavit Form (if no SSN issued) – www.hpla.doh.dc.gov**

☐ **Verification of licensure status must be received from original Jurisdiction and current Jurisdiction if your license in your original jurisdiction of licensure is not active.**
Verification Options
NURSYS: Complete verification on-line at www.nursys.com. Remember to select DC as the jurisdiction that will be receiving the verification. Attach a copy of your NURSYS receipt to this application.
Verification by mail: Submit your verification along with your application in a sealed envelope, as sent to you by the verifying Board of Nursing.

Please note: A copy of your license from another jurisdiction may not be used to verify your licensure status.

☐ **International applicant educated outside of the US or its territories must document evidence of spoken and written competency in English by providing one of the following:**
Graduation from a nursing program where English was the only language of instruction throughout the applicant's inclusive dates of attendance;

Proof of a total of twelve (12) months of full-time employment in the United States during the two (2) years immediately preceding the date of this application; or

Successful completion of TOEFL iBT or IELTS

☐ **Provide a detailed explanation if you answer "Yes" to any of the questions in Section 5. Submit copies of court reports, personnel action (eg. termination due to unsafe practice), actions taken against your license or other relevant documents.**

REMINDER: The DC Board of Nursing cannot issue a license without the results of a criminal background check. Please refer to Section 1A of the application.

APPLICATION FOR LICENSURE BY ENDORSEMENT

SECTION 5. SCREENING QUESTIONS Applicants must answer all of the following questions

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be issued a license if you have failed to file your District tax returns.

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following: — YES ☐ NO ☐

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

Information presented above is in compliance with the requirement to submit with your application for licensure under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

A	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES ☐ NO ☐
B.	Do you have a mental condition that currently impairs your ability to practice your profession?	YES ☐ NO ☐
C	Have you ever been convicted or arrested for a crime or misdemeanor (other than a minor traffic violation)?	YES ☐ NO ☐
D	Have you been terminated from or resigned from a clinical or professional training program due to a practice issue?	YES ☐ NO ☐
E.	Please answer with respect to DC or any other jurisdiction/state: (1) Have you withdrawn an application to practice your profession or voluntarily surrendered a license after formal charges have been filed against you or while under investigation? (2) Has any authority or peer review board taken adverse action against your license or privileges or informed you of any pending charges not previously reported to this Board? (3) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board? (5) Have you voluntarily surrendered your license? (6) Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility?	YES ☐ NO ☐
F.	Have you been party to a malpractice action or had a malpractice action brought against you?	YES ☐ NO ☐

SECTION 6. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

_____ _____ _____

LICENSEE SIGNATURE ***PRINT NAME*** ***DATE***

***PLEASE NOTE: PRINT AND MAIL ORIGINAL APPLICATION TO THE BOARD OF NURSING AND RETAIN A COPY FOR YOUR FILES.**

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.