NU REN

District of Columbia

DEPARTMENT OF HEALTH – HEALTH REGULATION AND LICENSING ADMINISTRATION

LPN RENEWAL APPLICATION

Please read instructions at the beginning of each section as you complete this form. See Section 2 for special information specific to your license. If you have any questions, call HRLA's Customer Service line Monday through Friday, 8:30AM to 4:30PM EST at 1-877-672-2174.

A Charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

SECTION 1. LICENSEE INFORMATION – Please provide the information requested below. If updated, check box provided at right. If you are changing your name, you must provide legal documentation for the name change. Acceptable documentation for individuals includes a copy of a marriage certificate, divorce decree, or court order.

Keep a copy of this renewal form and your payment for your records. Remember that you are required by law to notify the Board of any address change within 30 days of the change.

PLEASE PRINT **Name change due to: ☐ Marriage ☐ Divorce ☐ Court Order**

Full Name: ____________________ License Number: ____________________

Mailing Address: ____________________ *SSN: ____________________

City/State/Zip Code: ____________________ Birth date: ____________________

Phone: ____________________ Business Phone: ____________________

E-mail: ____________________ Business E-mail: ____________________

*Pursuant to D.C. Official Code Section 3-1205.5(b) (2001) (Health Occupations Revision Act), **applicants are required to provide a Social Security Number (SSN)** on applications for a professional license.

SECTION 2. CRIMINAL BACKGROUND CHECK (CBC)

IF YOU COMPLETED A CBC FOR THE PURPOSE OF LICENSURE THAT YIELDED FBI AND STATE RESULTS, YOU ARE NOT REQUIRED TO REPEAT THE CBC.

CONTINUING EDUCATION REQUIREMENT (CE not required for First Time renewal applicants.)

LPNs must complete eighteen (18) contact hours of continuing education in current area of practice. **NOT required for first-time renewal.**

Only contact hours obtained in the two (2) years immediately preceding the application date will be accepted. DO NOT send documentation verifying your compliance with the CE requirement unless asked to do so by the Board. The documents mailed to the Board will not be returned.

NURSING WORKFORCE SURVEY

Please complete and mail the attached 2015 "Nursing Workforce Survey" along with your renewal application.

SECTION 3. RENEWAL OPTIONS

Please check the appropriate box(es)		FEE
A. ☐	LPN Renewal	$145.00
B. ☐	*LPN Inactive	$145.00
C. ☐	**Late fee (if received after due date)	$ 85.00
D. ☐	***Reactivate (Inactive License)	$ 34.00

Make check or money order payable to DC TREASURER and Mail to:

HRLA 2
P.O. Box 37802
Washington, D.C. 20013

PLEASE NOTE

- ***Inactive status:** Prior to August 30th you may place your license on inactive status. While on inactive status you shall not be subject to the renewal fee and shall not practice as a nurse in the District.
- ****Late renewal:** Applications received after June 30th but prior to August 30th will be subject to an **$85.00 late fee**.
- *****Reactivation of inactive status:** To reactivate an inactive license you must pay the reactivation fee and comply with licensure renewal requirements.
- **Reinstatement**: After August 30th your license will expire and you will be required to apply for reinstatement of your license.

SECTION 4. Questions – Applicants MUST answer all of the following questions.

Answer questions A through I by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through G below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this form.

A. **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 or Permit** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).
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 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:

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)?

YES ☐ **NO** ☐

The information presented above is in compliance with the requirement to submit with your application for licensure or permit 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.).

Question	YES	NO
B. Since your last renewal, have you been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	☐	☐
C. Since your last renewal:		
(1) Have you withdrawn an application for licensure/certification/registration to practice your profession in any jurisdiction?	☐	☐
(2) Has any authority or peer review board taken adverse action against your license or privileges?	☐	☐
(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?	☐	☐
D. Do you have a physical or mental condition that currently impairs your ability to practice your profession?	☐	☐
E. Since your last renewal, have you been diagnosed or treated for substance abuse?	☐	☐
F. Since your last renewal, have you been involved in a malpractice suit? If yes, provide date of incident, allegation, and disposition of case.	☐	☐
G. Since your last renewal, have you ever been terminated or asked to resign from employment?	☐	☐
H. Do you currently practice your profession in the District of Columbia?	☐	☐
I. Will you have completed your Continuing Education as indicated in section 2, no later than June 30, 2015?	☐	☐

SECTION 5. 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	LICENSEE NAME (Please print)	DATE

Government of the District of Columbia
Department of Health

Health Regulation and Licensing Administration
Board of Nursing

Dear Nurse Colleagues,

On behalf of the District of Columbia Board of Nursing, I want to thank you for participating in this important workforce survey for Licensed Practical Nurses. Please take a few minutes to complete the attached workforce survey which will allow the Board of Nursing and the Health Regulation Licensing Administration (HRLA) to accurately capture, quantify, and analyze our current nursing workforce demographics. This survey will provide the information needed by the DC health care community to develop strategies for building the capacity needed to meet the workforce needs of the future.

The data will be used for workforce statistical analyses and reporting purposes ONLY.

We appreciate your cooperation and support.

Thank you,

Cathy S. Borris-Hale, RN, MHA, BSN
Chairperson
District of Columbia Board of Nursing

District of Columbia Board of Nursing
2015 - Nursing Workforce Survey

1. Jurisdiction

2. License Number

3. First Name ________________________________

4. Last Name ________________________________

5. What is your gender?
   a. Male
   b. Female

6. What is your race/ethnicity? (Mark all that apply)
   a. American Indian or Alaska Native
   b. Asian
   c. Black/African American
   d. Native Hawaiian or Other Pacific Islander
   e. White/Caucasian
   f. Hispanic/Latino

7. What is your date of birth?

				1	9		
Month		Day		Year			

8. What type of nursing degree/credential qualified you for your first U.S. nursing license?
   a. Vocational/Practical certificate-nursing
   b. Diploma-nursing
   c. Associate degree-nursing
   d. Baccalaureate degree-nursing
   e. Master's degree-nursing
   f. Doctoral degree-nursing

9. What is the name of the school (education program) you graduated from that qualified you for your first U.S. RN license?

   ____

10. In what city and state was this education program located?

   ________________   ______________
   City   State

11. What is your highest level of education?

    a. Vocational/Practical certificate-nursing
    b. Diploma-nursing
    c. Associate degree-nursing
    d. Associate degree-other field
    e. Baccalaureate degree-nursing
    f. Baccalaureate degree-other field
    g. Master's degree-nursing
    h. Master's degree-other field
    i. Doctoral degree-nursing
    j. Doctoral degree-other field

12. What type of license do you currently hold?
    a. RN
    b. LPN
    c. Advanced Practice RN license (include all advanced license statuses in your state)

13. What is the status of the license currently held?
    a. Active
    b. Inactive

14. Are you currently licensed/certified as a…
    a. Nurse Practitioner
    b. Clinical Nurse Specialist
    c. Certified Registered Nurse Anesthetist
    d. Certified Nurse Midwife
    e. Not licensed/certified as any of the above

15. What is your employment status? (Mark all that apply)
    a. Actively employed in nursing
        i. Yes
            1. Full-time
            2. Part-time
            3. Per diem
        ii. No
    b. Actively employed in a field other than nursing
        i. Yes
            1. Full-time
            2. Part-time
            3. Per diem
        ii. No
    c. Working in nursing only as a volunteer
    d. Unemployed
        i. Seeking work as a nurse
        ii. Not seeking work as a nurse
    e. Retired

16. If unemployed, please indicate the reasons.
    - a. Taking care of home and family
    - b. Disabled
    - c. Inadequate Salary
    - d. School
    - e. Difficulty in finding a nursing position
    - f. Other____

17. In how many positions are you currently employed as a nurse?
    - a. 1
    - b. 2
    - c. 3 or more

18. How many hours do you work during a typical week in all your nursing positions?

19. Please indicate the state and zip code of your primary employer.

State/Jurisdiction______________________

20. Please identify the type of setting that most closely corresponds to your primary nursing practice position.
    - a. Hospital
    - b. Nursing Home/Extended Care/Assisted Living Facility
    - c. Home Health
    - d. Correctional Facility
    - e. Academic Setting
    - f. Public Health
    - g. Community Health
    - h. School Health Service
    - i. Occupational Health
    - j. Ambulatory Care Setting
    - k. Insurance Claims/Benefits
    - l. Policy/Planning/Regulatory/Licensing Agency
    - m. Other

21. Please identify the position title that most closely corresponds to your primary nursing practice position.
    - a. Consultant/Nurse Researcher
    - b. Nurse Executive
    - c. Nurse Manager
    - d. Nurse Faculty
    - e. Advanced Practice Nurse
    - f. Staff Nurse
    - g. Other-Health Related
    - h. Other-Not Health Related

22. Please identify the employment specialty that most closely corresponds to your primary nursing practice position.
    i. Acute care/Critical Care
    ii. Adult Health/Family Health
    iii. Anesthesia
    iv. Community
    v. Geriatric/Gerontology
    vi. Home Health
    vii. Maternal-Child Health
    viii. Medical Surgical
    ix. Occupational health
    x. Oncology
    xi. Palliative Care
    xii. Pediatrics/Neonatal
    xiii. Public Health
    xiv. Psychiatric/Mental Health/Substance Abuse
    xv. Rehabilitation
    xvi. School Health
    xvii. Trauma
    xviii. Women's Health
    xix. Other

b. Please identify the type of setting that most closely corresponds to your secondary nursing practice position.
    i. Hospital
    ii. Nursing Home/Extended Care/Assisted Living Facility
    iii. Home Health
    iv. Correctional Facility
    v. Academic Setting
    vi. Public Health
    vii. Community Health
    viii. School Health Service
    ix. Occupational Health
    x. Ambulatory Care Setting
    xi. Insurance Claims/Benefits
    xii. Policy/Planning/Regulatory/Licensing Agency
    xiii. Other
    xiv. No Secondary Practice Position

c. Please identify the position title that most closely corresponds to your secondary nursing practice position.
    i. Consultant/Nurse Researcher
    ii. Nurse Executive
    iii. Nurse Manager
    iv. Nurse Faculty
    v. Advanced Practice Nurse
    vi. Staff Nurse
    vii. Other-Health Related
    viii. Other-Not Health Related
    ix. No Secondary Practice Position

d. Please identify the employment specialty that most closely corresponds to your secondary nursing practice position.

i. Acute care/Critical Care
ii. Adult Health/Family Health
iii. Anesthesia
iv. Community
v. Geriatric/Gerontology
vi. Home Health
vii. Maternal-Child Health
viii. Medical Surgical
ix. Occupational health
x. Oncology
xi. Palliative Care
xii. Pediatrics/Neonatal
xiii. Public Health
xiv. Psychiatric/Mental Health/Substance Abuse
xv. Rehabilitation
xvi. School Health
xvii. Trauma
xviii. Women's Health
xix. Other
xx. No Secondary Practice Position

e. Please list all states in which you hold an active license to practice as an RN:

______ ______ ______ ______ ______ ______

f. Please list all states in which you are currently practicing:

______ ______ ______ ______ ______ ______

g. In what country did you receive your entry-level education?

____