



NEW LICENSE APPLICATION
BOARD OF NURSING

Please read instructions before completing this form. If you have any questions, call HPLA Customer Service at **1-877-244-1689**, Monday through Friday, 8AM to 5PM EST. **A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)**

| SECTION 1. REQUESTED LICENSE TYPE/FEES (includes non-refundable application fee – see instructions) | | |
|--|--|--|
| Endorsement <input type="checkbox"/> LPN – <input type="checkbox"/> RN Licensed by Endorsement \$230.00 | Make check or money order payable to <u>DC Treasurer.</u> MAIL TO: Department of Health Health Professional Licensing Administration Board of Nursing 899 North Capitol St NE, First Floor Washington, DC 20002 Walk-in Service 899 North Capitol St., NE First Floor Washington, DC 20002 | |
| APRN Authorities <input type="checkbox"/> APRN – First time applicant Advance Practice and Registered Nurse by Endorsement (select one): \$375.00 <input type="checkbox"/> Nurse Anesthetist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse Midwife <input type="checkbox"/> Clinical Nurse Specialist | | |
| <input type="checkbox"/> Adding APRN authority to existing DC RN License Number: DC RN # _____ | | |
| Advanced Practice Registered Nurse (select one): \$230.00 <input type="checkbox"/> Nurse Anesthetist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse Midwife <input type="checkbox"/> Clinical Nurse Specialist | | |
| Advanced Practice Registered Nurse (select one): \$119.00 <input type="checkbox"/> Nurse Anesthetist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse Midwife <input type="checkbox"/> Clinical Nurse Specialist | | |
| Each additional APRN authority | | |
| Examination <input type="checkbox"/> LPN – <input type="checkbox"/> RN Licensed by Examination \$187.00 <input type="checkbox"/> LPN – <input type="checkbox"/> RN by Re-Examination \$85.00 | | |
| Duplicates <input type="checkbox"/> Duplicate Licenses (limit 5) _____ X \$34.00 | | |
| Total Enclosed \$ _____ .00 | | |

| HPLA ONLY | | |
|------------------|---------|-------|
| Check \$ | Check # | Staff |
| \$ _____ .00 | | |

| SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION | | | |
|--|-------------|--------------------|-------------------------------------|
| Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, please complete Section 4 on page 2. You must also provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders. | | | |
| _____ FIRST NAME | _____ MI | _____ LAST NAME | _____ SUFFIX (Jr., Sr., etc.) |

| | |
|--|--|
| _____ - _____ - _____ SOCIAL SECURITY NUMBER If applicant does not provide a social security number, a sworn affidavit is required. | _____ - _____ - _____ DATE OF BIRTH (mm/dd/yyyy) |
| _____ PLACE OF BIRTH Provide City and State for US birthplace or Country for foreign place of birth. | <input type="checkbox"/> Male <input type="checkbox"/> Female GENDER Please check the correct box. |

| SECTION 3. SUPPORTING DOCUMENTS REQUIRED | | |
|--|--|--------------------------|
| Please indicate the supporting documents you have included with this package or requested to be sent to the Board of Nursing. | | HPLA ONLY |
| A. Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name and SSN printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies. | YES <input type="checkbox"/> NO <input type="checkbox"/> | <input type="checkbox"/> |
| B. If a graduate of a nursing school other than in the United States and Canada, an official transcript of your Council for Graduates of Foreign Nursing Schools (CGFNS) certificate. * No copies accepted. Please indicate the country where your nursing school is located : <input type="checkbox"/> USA <input type="checkbox"/> Canada <input type="checkbox"/> Other _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | <input type="checkbox"/> |
| C. Official transcript (with seal) from the applicant's school of nursing, with cover letter from school. May be sent directly from the school, but is preferred that it accompany the application in a sealed envelope. EXAM APPLICANTS ONLY | YES <input type="checkbox"/> NO <input type="checkbox"/> | <input type="checkbox"/> |
| D. Copy of most recently obtained license from other state or territory. | YES <input type="checkbox"/> NO <input type="checkbox"/> | <input type="checkbox"/> |

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SECTION 5C. PREFERRED MAILING 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. The address that will appear on your license will be your business address.

- HOME BUSINESS

SECTION 6A. NURSING SCHOOLS ATTENDED

List all nursing schools that you have attended, in reverse chronological order, beginning with the most recent at the top.

EXAM APPLICANTS ONLY: Transcripts must be provided for all schools listed below.

| MANDATORY FIELD School Name, City, State, Country | Number of Hours Completed | Date of Graduation | Type of Degree/Certificate |
|--|------------------------------|-----------------------|-------------------------------|
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SECTION 6B. PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a license. Provide letters of verification from original and current jurisdictions (if different).

| MANDATORY FIELD Jurisdiction | Date License Was First Obtained | License Number |
|---------------------------------|------------------------------------|----------------|
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SECTION 7. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer all of the following questions by placing an "X" in the appropriate boxes. If you answer "Yes" to questions B through J 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 application.

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 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)?

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.).

YES NO **HPLA ONLY**

| | | | |
|---|------------------------------|-----------------------------|--------------------------|
| B. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <input type="checkbox"/> |
| C. Have you ever been convicted or arrested for a crime (other than minor traffic violations) not previously reported to the Board? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <input type="checkbox"/> |

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION**

NEW LICENSE APPLICATION

| | | | |
|--|---------------------------------|--------------------------------|--------------------------|
| D. Are you now or have you ever been licensed in DC or any other state/jurisdiction? (If "Yes," be sure to complete Section 6B of this form.) | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <input type="checkbox"/> |
| E. Have you ever been party to a malpractice action or had a malpractice action brought against you? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <input type="checkbox"/> |
| F. Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <input type="checkbox"/> |
| G. Have you ever been terminated from or resigned from a clinical or professional training program? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <input type="checkbox"/> |
| H. Do you have a physical or medical condition that currently impairs your ability to practice your profession? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <input type="checkbox"/> |
| I. (1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you 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? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <input type="checkbox"/> |
| J. Have you ever been terminated or asked to resign from employment since obtaining your (professional) license? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <input type="checkbox"/> |

SECTION 8. 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.

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|---------------------------|----------------------------|-------------|--------------------------|
| | | | HPLA ONLY |
| LICENSEE SIGNATURE | NAME (Please Print) | DATE | <input type="checkbox"/> |

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