



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



**APPLICATION INSTRUCTIONS AND FORM
FOR LICENSURE BY EXAMINATION
IN THE DISTRICT OF COLUMBIA**

Your interest in becoming licensed as a registered nurse or practical nurse in the District of Columbia is welcomed. We look forward to providing expedient and professional service. However, the quality of our service is dependent on the completeness of your application. Please read the instructions carefully.

This package contains the forms to apply for a nursing license in the District of Columbia. Follow the instructions provided below and complete all sections. If you require more space to provide explanations for screening questions, attach printed or typed responses to the form.

THE APPLICATION PROCESS

Upon receipt of the required application documents, the District of Columbia Board of Nursing will review your application. Upon final approval, you will be issued a license to practice in the District of Columbia.

If you submit an application that is incomplete or otherwise deficient, Health Regulation and Licensing Administration's (HRLA) processing staff will notify you of the deficiencies. If the Board has questions or concerns, you will also be notified.

WHERE TO FILE

Documents should be sent to the following address:

Board of Nursing
P. O. Box 37802
Washington, DC 20013

If you have any questions, call HRLA's Customer Service toll free line at 1-877-672-2174 between 8:15 a.m. and 4:45 p.m. EST Monday through Friday. Please read these instructions carefully to facilitate prompt processing of your application. Illegible applications and applications submitted without required signatures or with incorrect fees will be returned in their entirety, including fees. Please print or type all information except signatures.

FEES

Please enclose check or money order made payable to DC Treasurer.

SOCIAL SECURITY NUMBER

Social Security Number must be provided. If you don't currently have a social security number you must submit the attached "Affidavit in Support of Application for District of Columbia Licensure"

LETTER OF RECOMMENDATION FROM NURSE ADMINISTRATOR (if *transcript is not provided)

Applicants may submit a letter of recommendation from the Nurse Administrator of their nursing program, school or college. The letter may be sent directly from the school, but is preferred that it accompany the application in a sealed envelope.

**Applicant will not be licensed until the official transcript is received indicating date the degree was conferred or date of graduation.*

OFFICIAL TRANSCRIPT

An Official Transcript must be *received indicating date the degree was conferred or date of graduation*. Official transcript (with seal) from the applicant's school of nursing, may be sent directly from the school, but is preferred that it accompany the application in a sealed envelope.

Please note: *Applicant will not be licensed until the official transcript is received indicating date the degree was conferred or date of graduation.*

CGFNS CERTIFICATION – INTERNATIONAL APPLICANTS

Graduates of nursing schools which are not located in the United States or Canada must submit an official CGFNS certificate. No copies accepted. Contact CGFNS at www.cgfns.org to apply for CES certification.

To sit for NCLEX you must have AUTHORIZATION TO TEST (ATT)

In order to receive your ATT, you must pay PearsonVue \$200.00. You can register:

Online at www.pearsonvue.com/nclex

By mailing your certified check, cashier's check or money order payable to NCSBN to:

NCLEX Operations

P.O. Box 64950

St. Paul, MN 55164-0950

By calling 1-866-49NCLEX to register by phone

MISSED DATE SCHEDULED TO SIT FOR NCLEX

If you are unable to sit for examination on the date scheduled you will need to reapply to sit for examination with NCLEX only. You will not be required to submit another application to the Board of Nursing unless you have failed the examination or your application was submitted more than 1 year ago.

APPLICATION STATUS

You will be notified in writing of any deficient or missing items or you can check the status of your licensure application online. Go to <https://app.hpla.doh.dc.gov/mylicense/>. Enter your Social Security Number and Last Name to register. Establish your User Name and Password --- then once you have successfully logged-in click on "View Checklist". The status of your application is available the next day after the application has been entered online. As information is received or as action is taken, the information is recorded in the database and automatically posted to the Status Check. After you are licensed this information is no longer available at this site. You can then verify your licensure status at <http://app.hpla.doh.dc.gov/weblookup/>

COMPLETING THE LICENSURE BY EXAMINATION APPLICATION

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.

MANNER OF PAYMENT OF LICENSURE FEES

Fees are payable by check or money order – Do NOT send cash – and should be made payable to DC Treasurer and submitted with your application packet. You may pay the license fee by a single check or money order. It is recommended that you pay by check, so that you have ready proof of payment. Please print your name on your check, if it is not pre-printed.

PASSPORT PHOTO

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.

APPLICANT NAME / DEMOGRAPHIC INFORMATION

Enter your 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 include a marriage certificate, divorce decree, court order or spouse's death certificate.

SOCIAL SECURITY NUMBER

International applicants: A Tax ID number will **NOT** be accepted in lieu of a social security number.

HOME ADDRESS / BUSINESS ADDRESS

Include both your home and business addresses in the sections provided. If you supply a PO Box for either address, you must also supply a corresponding street address for each PO Box used.

CRIMINAL BACKGROUND CHECK

IN THE DC AREA:

L1 ENROLLMENT: Visit <http://www.L1ENROLLMENT.COM/state/?st=DC> to schedule an appointment

OUTSIDE OF THE DC AREA: Call L1 Enrollment at 1-877-783-4187 to pay for the processing of your fingerprints and to obtain a mailing address for submission of your fingerprint card

SCREENING QUESTIONS

If you have been convicted of a crime, been terminated due to your clinical practice or have had actions taken against your license please provide official documentation which details the outcome or current status of the case.

If you answer "yes" to questions A through G, please provide a complete explanation on a separate sheet of paper. If more space is required 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.

LICENSEE AFFIDAVIT

By signing the application you are attesting under penalty of perjury that all information and attached documents are true to the best of your knowledge.

SUPPORTING DOCUMENTS REQUIRED

Submit all required supporting documents along with your application. **Keep a photocopy of all supporting documents for your records.**

ADDITIONAL INFORMATION

CHECKING STATUS OF APPLICATION

You can check the status of your licensure application online. Go to www.doh.dc.gov and click on Application Status or <https://app.hpla.doh.dc.gov/mylicense/>. Enter your [Social Security Number](#) and [Last Name to register. Establish](#) your [User Name](#) and [Password](#) --- then once you have successfully logged-in click on "[View Checklist](#)". The status of your application is available the next day after the application has been entered online. As information is received or as action is taken the information is recorded in the database and automatically posted to the Status Check. After you are licensed this information is no longer available at this site. You will be able to view your licensure status and obtain your license number at <http://app.hpla.doh.dc.gov/weblookup/> or www.doh.dc.gov and click on Online Professional License Search.

LICENSURE RENEWAL

RN licenses expire June 30 of even numbered years. **Your initial license will be valid only for the balance of the current renewal cycle. Your licensure fee will not be prorated.** You will be mailed a renewal notice (to your address of record) prior to the expiration of your license/certification. Upon completion of the renewal application and payment of the renewal fee, your license will be renewed for a two-year period.

RETURNED CHECK POLICY

A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208). Any further payments will need to be paid by money order or certified check.

CHANGE OF ADDRESS NOTIFICATION

You should know that you are required by regulation to report all changes of your business or residence address to the Board within 30 days, failure to do so is punishable by a \$100 fine for first offense and higher for subsequent offenses. HRLA will update the address change in your database record. Requests for address change should be made via fax to 202-724-5145 or letter sent to HRLA at the address in the middle of page 1. Without an updated address, you may not receive your renewal notice.

CE REQUIREMENTS FOR RENEWAL [Not required for first time renewals]

RNs: 24 Contact Hours

(1) Contact Hour Option: Provide an original verification form signed or stamped by the program sponsor.

(2) Academic Option: Provide proof of having completed an undergraduate or graduate course, in nursing or relevant to the practice of nursing.

(3) Teaching Option: Provide evidence of having developed or taught a continuing education course or educational offering approved by the board or a board approved accrediting body. Applicants may receive four (4) contact hours for each approved course contact hour. (This is not an option for nurses required to develop and teach in-service education courses or educational offering as a condition of employment)

(4) Author or Editor Option: Provide evidence of authorship or editor of a book, chapter or published peer reviewed periodical, if the periodical has been published or accepted for publication during the period for which credit is claimed. (Meets continuing education requirement)

PLEASE NOTE: All continuing education must be relevant to your current field of practice.



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



APPLICATION FOR LICENSURE BY EXAMINATION
BOARD OF NURSING

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 HRLA 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: RN LPN

Licensure by Examination **\$187.00**

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

Check or money order payable to:
DC Treasurer

MAIL:
Board of Nursing
P.O. Box 37802 –
Washington, D.C. 20013

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.)

Name of Nursing School Attended: _____ Country: _____ Graduation Date: _____

DEGREE(S): AA DIPLOMA BSN MSN OTHER DEGREE _____

_____/_____/_____
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.hrla.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

LANGUAGE(S) SPOKEN:

Language(s) spoken other than English:

<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Spanish	<input type="checkbox"/> French
<input type="checkbox"/> Other _____	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> German	<input type="checkbox"/> Arabic
		<input type="checkbox"/> Other _____	

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 3A. 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 3B. TRAINING PROGRAM (MANDATORY)

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

IMPORTANT CONTACT INFORMATION

District of Columbia Health Regulation Licensing Administration
 Location: 899 North Capitol Street, N.E., 2nd Floor - Washington, D.C. 20002
 Mail: Board of Nursing – P.O. Box 37802 – Washington, D.C. 20013

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

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.

If not provided previously submit an official transcript from the applicant's school of nursing, must accompany the application in a sealed envelope. Or

Applicant will not be licensed until the official transcript is received indicating date the degree was conferred or date of graduation.

If you are requesting special accommodations to sit for NCLEX, provide the following information:

1. Identify the accommodations being requested
2. Submit a letter from the appropriate health professional which confirms the disability, and provides information describing the accommodations required
3. Submit a letter from your education program, indicating the modifications granted by the program

If you answered "Yes" to any of the questions in Section 5; if you have not done so already, provide a detailed explanation on a separate sheet of paper. Submit copies of relevant court reports, personnel actions, actions taken against your license or other relevant documents.

SECTION 5. SCREENING QUESTIONS Applicants must answer all of the following questions		
<p style="text-align: center;">Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> 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)? <p>Information presented above is in compliance with the requirement to submit with your application for licensure under the <i>Clean Hands Before Receiving a License or Permit Act of 1996</i>, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).</p>		YES <input type="checkbox"/> NO <input type="checkbox"/>
A.	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"/>
B.	Do you have a mental condition that currently impairs your ability to practice your profession?	YES <input type="checkbox"/> NO <input type="checkbox"/>
C.	Have you ever been convicted or arrested for a crime or misdemeanor (other than a minor traffic violation)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
D.	Have you been terminated from or resigned from a clinical or professional training program due to a practice issue?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
F.	Have you been party to a malpractice action or had a malpractice action brought against you?	YES <input type="checkbox"/> NO <input type="checkbox"/>
SECTION 6. LICENSEE AFFIDAVIT		
<p><i>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.</i></p>		
_____ LICENSEE SIGNATURE		_____ PRINT NAME
		_____ DATE
*PLEASE NOTE: PRINT AND MAIL ORIGINAL APPLICATION TO THE BOARD OF NURSING AND RETAIN A COPY FOR YOUR FILES.		