



FOR OFFICE USE ONLY
Receipt #
ID #
Issue Date
License #

**Rhode Island
Board of Nurse Registration and Nursing Education**

Room 103
3 Capitol Hill
Providence, RI 02908-5097

***Instructions and
License Application for APRN:***

Select 1 Population Focus

- | | |
|---|--|
| <input type="checkbox"/> CNP Adult/gerontology | <input type="checkbox"/> CNS Adult/gerontology |
| <input type="checkbox"/> CNP Family/individual across the lifespan | <input type="checkbox"/> CNS Family/individual across the lifespan |
| <input type="checkbox"/> CNP Neonatal | <input type="checkbox"/> CNS Neonatal |
| <input type="checkbox"/> CNP Pediatric | <input type="checkbox"/> CNS Pediatric |
| <input type="checkbox"/> CNP Psychiatric/mental health | <input type="checkbox"/> CNS Psychiatric/mental health |
| <input type="checkbox"/> CNP Women's health/gender related | <input type="checkbox"/> CNS Women's health/gender related |
| <input type="checkbox"/> CRNA Family/individual across the lifespan | |

MILITARY STATUS ELIGIBILITY	<i>(Documentation Required) see next page for instructions</i>
Please check ONE of the following criteria for expedited application:	
<input type="checkbox"/> I am in active military duty or a reservist	
<input type="checkbox"/> I am a military veteran with honorable discharge	
<input type="checkbox"/> I am the spouse of someone in active military duty or the spouse of a reservist	

Applicant - Print Name

--	--	--

LAST NAME

FIRST NAME

MI

Do Not Hand Deliver - Application Must Be Mailed

Phone: (401) 222-5700

TTY/TDD: (800) 745-5555

Fax: (401) 222-6683

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Application Process Overview.....	3
Instructions for Completing Application.....	4
Application Materials	
Application.....	5-8
Application Checklist.....	9
Interstate Verification Form - ALL State(s) of Licensure.....	10
RI Uniformed Controlled Substances Act Registration (CSR).....	11

Licensure Requirements

For all Advanced Practice Nurse applicants:

- **Must hold an active Rhode Island RN license or an active RN license in a Compact State.**
- Application fee \$145.00 - Make a check or money order (in U.S. Funds only) payable to **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NONREFUNDABLE.
- Recent passport type photograph
- Official transcript submitted directly from educational program to the Board which includes the degree granted and date awarded ***Fascimiles will not be accepted.*** To be eligible for licensure in the State of Rhode Island, ***you must be a graduate of a nursing program.***
- Letter of certification directly from professional certifying organization
- Verification of licensure directly from the Board of Nursing in each state applicant has been granted a license to practice as an advanced practice nurse. Be sure to sign and complete the identifying information on each form. HEALTH must receive these verifications directly from the licensing authority. You may obtain the mailing address of all U.S. licensing authorities at the National Council of State Boards of Nursing web site, or by calling the State Board in question. Please, ***do not*** contact the Rhode Island Board for mailing addresses of other licensing authorities.

www.ncsbn.org
- All applicants must apply to the Department of Attorney General (“AG”) for a national background check supported by fingerprints and a state background check. The report MUST be sent directly from the Department of Attorney General (“AG”) to the RI Board of Nursing. For information on this process please visit <http://www.riag.state.ri.us/bci/records.php>

Note: All applicants for prescriptive privileges who wish to prescribe controlled substances must complete the enclosed Rhode Island Uniformed Controlled Substances Act Registration (CSR) (page 11). A Federal DEA registration number will not be issued without proof the practitioner has a Rhode Island issued CSR. The fee for a CSR is an additional \$200.00 for two years and will be renewable every other year with your advanced practice license. The CSR can only be issued to a Rhode Island practice address.

APPLICATION PROCESS OVERVIEW

Military Expedited

If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Rules and Regulations/Laws

To obtain the Rules and Regulations for your profession visit the following web site. From the list click on your profession.

<http://www.health.ri.gov/licenses/>

Rhode Island General Laws pertaining to the Practice of Nursing may be downloaded at the following web sites:

www.rilin.state.ri.us/statutes/title5/5-34/index.htm

www.rilin.state.ri.us/Statutes/TITLE5/5-34.2/INDEX.HTM

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation, and the Rhode Island Board of Nurse Registration and Nursing Education (Board).

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 9) must be received by this Office for an application to be considered complete. If you do not complete the application process and obtain a license within one year, a new application must be submitted.

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice, criminal or disciplinary history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received and a decision to be made regarding issuance of your license.

Licenses will be issued within 7-10 working days following the approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished on the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. Visit the following website to obtain a change of address form.

<http://www.health.ri.gov/forms/changeofaddress/NurseChangeAddressForm.pdf>

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed by the Board. Be advised, you may be required to appear for an interview. NOTE: You may ***not*** practice in Rhode Island until you have received a license number.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-5700.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application pages (5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee payable to **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is **NONRE-FUNDABLE**.
3. Complete all application materials as instructed and arrange them in the order listed on the application checklist (page 9). Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

<p style="text-align: center;">Rhode Island Department of Health Board of Nurse Registration and Nursing Education Room 103, 3 Capitol Hill Providence, RI 02908-5097</p>
--



State of Rhode Island Board of Nursing Registration and Nursing Education

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., Dr., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

 - -

U.S. Social Security Number

“Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State.”

3. Gender

 Male Female

4. Date of Birth

 / /

Month

Day

Year

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 -

Home Phone

State

 -

Zip Code

Postal Code, If NOT U.S.

 -

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address

(ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 -

Business Phone

Extension

State

 -

Zip Code

Postal Code, If NOT U.S.

 -

Business Fax

7. Preferred Mailing Address Please check <u>ONE</u>	<input type="checkbox"/> Please use my Home Address as my preferred mailing address <input type="checkbox"/> Please use my Business Address as my preferred mailing address
--	--

8. Qualifying Education Please list the name and information about the school that you attended which led to your advanced practice license.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; height: 20px; width: 100%;"></td> </tr> <tr> <td style="font-size: 8px;">Type of School (University, College, Trade/Technical School etc.)</td> </tr> <tr> <td style="border: 1px solid black; height: 20px; width: 100%;"></td> </tr> <tr> <td style="font-size: 8px;">Name of School</td> </tr> <tr> <td>Year Graduated: <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td align="center" colspan="4" style="font-size: 8px;">Year</td> </tr> </table> </td> </tr> </table>		Type of School (University, College, Trade/Technical School etc.)		Name of School	Year Graduated: <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td align="center" colspan="4" style="font-size: 8px;">Year</td> </tr> </table>					Year			
Type of School (University, College, Trade/Technical School etc.)														
Name of School														
Year Graduated: <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td align="center" colspan="4" style="font-size: 8px;">Year</td> </tr> </table>					Year									
Year														

9. Certification Please provide your Certification Information here.	Organization Granting Certification _____
--	---

10. Original APRN State License Please answer the question and list state(s), if applicable	Have you ever held, or do you currently hold, a license in another state? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to this question is “yes” , list the original state of licensure, license number, original issue date, and, if applicable, enter all other state abbreviation(s) of licenses in Question 11 (below): <table style="width:100%; border-collapse: collapse;"> <tr> <td align="center" style="width: 50%;">Original Licensure State and License Number</td> <td align="center" style="width: 50%;">Original Issue Date</td> </tr> <tr> <td style="border-collapse: collapse;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 100px; height: 20px;"></td> </tr> <tr> <td align="center" style="font-size: 8px;">State</td> <td></td> <td align="center" style="font-size: 8px;">License Number</td> </tr> </table> </td> <td style="border-collapse: collapse;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td align="center" style="font-size: 8px;">Month</td> <td align="center" style="font-size: 8px;">Day</td> <td align="center" style="font-size: 8px;">Year</td> <td></td> <td></td> <td></td> </tr> </table> </td> </tr> </table>	Original Licensure State and License Number	Original Issue Date	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 100px; height: 20px;"></td> </tr> <tr> <td align="center" style="font-size: 8px;">State</td> <td></td> <td align="center" style="font-size: 8px;">License Number</td> </tr> </table>				State		License Number	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td align="center" style="font-size: 8px;">Month</td> <td align="center" style="font-size: 8px;">Day</td> <td align="center" style="font-size: 8px;">Year</td> <td></td> <td></td> <td></td> </tr> </table>							Month	Day	Year			
Original Licensure State and License Number	Original Issue Date																						
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 100px; height: 20px;"></td> </tr> <tr> <td align="center" style="font-size: 8px;">State</td> <td></td> <td align="center" style="font-size: 8px;">License Number</td> </tr> </table>				State		License Number	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td align="center" style="font-size: 8px;">Month</td> <td align="center" style="font-size: 8px;">Day</td> <td align="center" style="font-size: 8px;">Year</td> <td></td> <td></td> <td></td> </tr> </table>							Month	Day	Year							
State		License Number																					
Month	Day	Year																					

11. Nursing Licensure List all states or countries in which you are now, or ever have been licensed to practice as an APRN NOTE: Please indicate the current <u>license type</u> and <u>status</u> of each entry.	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: center; font-size: 8px;">State/Country:</th> <th style="width: 30%; text-align: center; font-size: 8px;">License Type (APRN) `</th> <th style="width: 40%; text-align: center; font-size: 8px;">Status</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> <tr><td>_____</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr> </tbody> </table>	State/Country:	License Type (APRN) `	Status	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
State/Country:	License Type (APRN) `	Status																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																
_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive																																

12. Criminal Convictions Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided. If necessary, you may continue on a separate 8½ x 11 sheet of paper.	Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? <input type="checkbox"/> Yes <input type="checkbox"/> No Abbreviation of State and Conviction ¹ (e.g. CA - Illegal Possession of a Controlled Substance): <table style="width:100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 70%;"></td> <td style="border: 1px solid black; width: 10%; text-align: center; font-size: 8px;">Month</td> <td style="border: 1px solid black; width: 10%; text-align: center; font-size: 8px;">Year</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border: 1px solid black; width: 10%; text-align: center; font-size: 8px;"> </td> <td style="border: 1px solid black; width: 10%; text-align: center; font-size: 8px;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border: 1px solid black; width: 10%; text-align: center; font-size: 8px;"> </td> <td style="border: 1px solid black; width: 10%; text-align: center; font-size: 8px;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border: 1px solid black; width: 10%; text-align: center; font-size: 8px;"> </td> <td style="border: 1px solid black; width: 10%; text-align: center; font-size: 8px;"> </td> </tr> </table>		Month	Year									
	Month	Year											

13. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.



1. Are there any charges or investigations pending, in any state, against you? Yes No

2. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? Yes No

3. Have you ever had any disciplinary action(s) taken, or is any pending against your license to practice nursing, or any other licenses, registrations or certifications that you hold; or are any complaints pending in any state? Yes No

Note: If you answered "yes" to any of these questions you must explain below or, if needed, on a separate sheet of paper.

14. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Nurse Registration and Nursing Education any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as nurse in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Nurse Registration and Nursing Education of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)

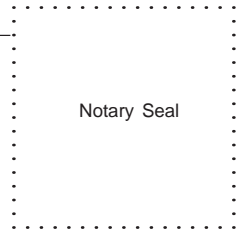
The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp)

Signature of Notary

Notary No/Commission No.

Commission Expiration Date (MM/DD/YY)



15. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.



Write your name on the back of the photograph, and provide the date that the photograph was taken.

Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- I have read and understand the “Instructions for Completing the Application”.
- I have completed the Rhode Island Board application as instructed (pages 5-8).
- I have attached the cover page of the application.
- I have completed Section 14, “**Affidavit of Applicant**” (page 8), and had the form notarized by a notary public.
- I have attached a photograph to Section 15, “**Recent Photograph**” (page 8) as instructed. I have verified that it meets the photograph requirements as stated in the application.
- I have attached a photocopy of an active, out-of-state APRN license.
- I have a **check or money order** (preferred), made payable (in U.S. funds only) to the “**RI General Treasurer**” in the amount of \$145.00 and attached it to the upper left-hand corner of the first (Top) page of the application.
- I have arranged my Board Application materials in the following order.
 1. Fee (attached as instructed).
 2. Board Application (including cover page) (pages 5-8)
 3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application] **MUST** indicate the section for which the information is being reported.]
- I have mailed the above application materials directly to the Rhode Island Board of Nurse Registration and Nursing Education.

Required Forms

- I have completed and mailed the following forms as instructed.
 1. Interstate Verification Form - to all other states of licensure

Other Documents

- I have requested a school transcript as instructed.
- I have applied for the RI Uniformed Controlled Substances Act Registration (CSR), completed the form (page 11) and enclosed an **additional \$200.00**
- I have requested a national background check supported by fingerprints and a state background check to be sent directly to the Board of Nursing.



Rhode Island Board of Nurse Registration and Nursing Education

Substitute forms are not acceptable - This form may be duplicated as needed.

Room 103, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-5700

INTERSTATE VERIFICATION FORM - ALL STATES OF LICENSURE

I am applying for a license to practice as an APRN in the State of Rhode Island. The Rhode Island Board of Nurse Registration and Nursing Education requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Nurse Registration and Nursing Education at the above address.

_____	_____	_____
Print/Type Full Name	Signature	Date
_____	_____	_____
Previous Names Used	Social Security Number	Date of Birth
_____	_____	
License Number	Date Issued	

THIS SECTION TO BE COMPLETED BY THE NURSING BOARD

Basis for Issuing License:

APRN

Licensed by:

Endorsement Exam

License Status:

Active Inactive Lapsed

Original Date Issued:

Expiration Date:

Questions:

- Has this registered nurse ever been investigated by your Board? Yes No
- Has this registered nurse incurred any disciplinary proceedings in your state, or is any action pending? Yes No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
- Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

Signature

Date

Type or Print Name

Title

Full Name of Licensing Board

.....
.....
.....
Please Affix
Board Seal Here
.....
.....
.....

Please return directly to the Board at the above address. Thank you for your prompt cooperation.



Rhode Island Board of Nurse Registration and Nursing Education

Room 103, 3 Capitol Hill
 Providence, RI 02908-5097
 (401) 222-5700

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniformed Controlled Substances Act Registration (CSR). **I understand that there is an additional \$200.00 fee for this Registration and that the check or money order must be made out to the RI General Treasurer.**

Print/Type Full Name	Rhode Island Business Name	Current RI NPP/PCNS LicenseNo.
Signature	Rhode Island Business Address	Business Telephone
Date		Business Fax

Complete this application for registration to prescribe controlled substances in the State of Rhode Island	The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site: <p style="text-align: center;">www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm</p>
A CSR is not required if there will be no controlled substances prescriptions prescribed in this state. The CSR is renewed at the same time that the professional license is renewed.	<p style="text-align: center;">Drug Schedule (Check all that apply)</p> <p style="text-align: center;"> <input type="checkbox"/> Schedule II <input type="checkbox"/> Schedule III <input type="checkbox"/> Schedule IV <input type="checkbox"/> Schedule V </p> <p>A Copy of the DEA Registration must be provided to the Nursing Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*</p> <p>All Applicants MUST answer the following:</p> <p>A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">If you answered "Yes" to question "A" or "B" attach an explanation to this form.</p>
NOTE: Read Important Information on the bottom of this application.	

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "**VOID**". Licensed drug facilities and licensed practitioners with prescriptive privileges, cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: www.dea diversion.usdoj.gov/drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units maybe dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.