

RN/LPN - Checklist

- App. & Fee
- Proof of Residency
- NCRC
- License Verifications
- CGFNS

FOR OFFICE USE ONLY



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Receipt #

ID#

Issue Date

License #

Rhode Island

Board of Nurse Registration and Nursing Education

Room 103
 3 Capitol Hill
 Providence, RI 02908-5097

Application For
License By Endorsement As A

- Registered Nurse**
- Licensed Practical Nurse**

This application is for those who are licensed in another state and are applying for a Rhode Island Nurse for the first time. **DO NOT** use this application if you were previously licensed in Rhode Island.

MILITARY STATUS ELIGIBILITY

(Documentation Required)
see next page for instructions

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist
- I am a military veteran with honorable discharge
- I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

Empty box for Last Name

LAST NAME

Empty box for First Name

FIRST NAME

Empty box for Middle Initial

MI

**This application form (dated 01/08/2016) replaces all previous versions.
 Prior versions of the application will not be accepted or processed.**

Phone: (401) 222-5700

TTY/TDD: (800) 745-5555

Fax: (401) 222-6683

GENERAL INFORMATION

****VERY IMPORTANT****

Do not apply for a RI license if you have an active license in your state of legal residence is and that state is part of the Nurse Licensure Compact. Please visit <https://www.ncsbn.org/compacts.htm> in order to determine if your state is part of the Compact.

If your primary residence is in a state that is not part of the Compact, then you must obtain a RI license in order to practice in this state by completing this application.

Application Checklist

U.S. Graduates

- Completed, Signed Application with Cover Page
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$135.00** for RN or **\$45.00** (for LPN) and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE
- Proof of Residency. Acceptable documents are copy of driver's license, tax return or lease and must include address)
- Graduation from a nursing program
- Photocopy of an **active, out-of-state-license**
- License Verification from all other state boards in which a license has been issued. Verification in compact states is done online at www.NURSYS.com
For non-compact states you may obtain the mailing address of all U.S. licensing authorities at www.ncsbn.org and use the verification form attached with this application. (NOTE: Non-compact state verifications may take several weeks to be sent to us.)
- All applicants must apply to the Department of Attorney General 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 to the RI Board of Nursing. For information on this process please visit <http://www.riag.state.ri.us/homeboxes/BackgroundChecks.php>
- 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.

Foreign-Trained Nurses

- Requirements listed under U.S. Graduates.
- Completion of the requirements of the **Commission of Graduates of Foreign Nursing Schools**. For information on this process please visit www.cgfns.org/services

Rules and Regulations: <http://sos.ri.gov/rules/index.php>

Nurse Practice Act: www.rilin.state.ri.us/statutes/title 5/5-34/index.htm

All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year, a new application must be submitted.

If you have a criminal 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. To check if your license has been issued go to: <https://healthri.mylicense.com/Verification/>

NOTE: You may not practice in Rhode Island until you have received a license number. If you have any questions about this application process please contact the board staff at 401-222-5700.

7. Preferred Mailing Address

Please check ONE

- Please use my **Home Address** as my preferred mailing address
- 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 licensure as a nurse.

Type of School (University, College, Trade/Technical School etc.)

Name of School

Date Graduated:

State Month Day Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

Major

U.S Graduate Foreign Graduate

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? Yes 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 10 (below):

Original Licensure State and License Number **Original Issue Date**

State License Number Month Day Year

10. Nursing Licensure

List all states or countries in which you are now, or ever have been licensed to practice as a nurse, or any other profession.

State/Country: _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	State/Country: _____	<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	_____	<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



DOCUMENTATION: Send Interstate Verification Forms to each entity. (See pages 10 and 11)

Please indicate which state verifications you have requested through NURSYS (if any)

11. 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?

Yes No

Abbreviation of State and Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance):

_____	Month	<input type="text"/>	Year	<input type="text"/>
_____		<input type="text"/>		<input type="text"/>
_____		<input type="text"/>		<input type="text"/>

12. 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 on a separate sheet of paper.

13. 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 Seal

Notary No/Commission No.

Commission Expiration Date (MM/DD/YY)



Rhode Island Board of Nurse Registration and Nursing Education

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

INTERSTATE VERIFICATION FORM - OTHER STATES OF LICENSURE

I am applying for a license to practice as a nurse 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	Daytime Phone Number

THIS SECTION TO BE COMPLETED BY THE NURSING BOARD

Basis for Issuing License: <input type="checkbox"/> RN <input type="checkbox"/> LPN/VN		
Licensed by: <input type="checkbox"/> Endorsement <input type="checkbox"/> Waiver		
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

Questions:

1. Has this nurse ever been investigated by your Board? Yes No
2. Has this nurse incurred any disciplinary proceedings in your state, or is any action pending? Yes No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
4. 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	Please Affix Board Seal Here
Type or Print Name		
Title		
Full Name of Licensing Board		

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

Applicant: Print your complete last name >



State of Rhode Island and Providence Plantations Department of Health

This information is completely voluntary and will NOT affect your Application in any way.

VOLUNTARY RACE/ETHNICITY QUESTIONS*

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

1. Ethnicity: Are you Hispanic or Latino? (Mark “No” if not Hispanic or Latino.)

No, not Hispanic or Latino Yes, Hispanic or Latino

2. Race: What is your race? (Mark one or more.)

American Indian or Alaska Native Black or African American White
 Asian Native Hawaiian or other Pacific Islander

For the purposes of the above questions kindly use the “Federal Minimum Data Collection” explanations listed below:

1. Ethnic Categories:

Hispanic or Latino

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish origin” can be used in addition to “Hispanic or Latino.”

Not Hispanic or Latino

A person who is not Hispanic or Latino.

2. Racial Categories:

American Indian or Alaskan Native

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American

A person having origins in any of the Black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American”.

Native Hawaiian or Other Pacific Islander

A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

*This information is being collected in accordance with the Department of Health’s Policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.
