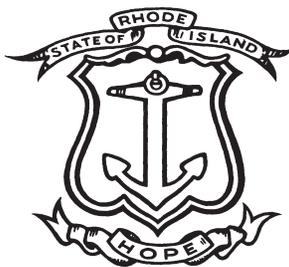


The issuance of this license is conditioned on your immediate availability and willingness to work in a clinical setting.



FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
ID#:
Receipt #:

Center for Professional Licensing

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Emergency 90 Day Temporary License

- Emergency Medical Responder Paramedic
 Emergency Medical Technician

Dietitian/Nutritionist

-
- Practical Nurse APRN Focus _____
 Registered Nurse Reciprocity - Active License In another State Graduate Nurse

-
- Nursing Assistant Nursing Student - See Instructions
 Reciprocity - Active License In another State

Applicant - Print Name

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LAST NAME

FIRST NAME

MI

Phone: (401) 222-2828

TTY/TDD: (800) 745-5555

Fax: (401) 222-1272

Licensure Information

As part of our response to coronavirus disease 2019 (COVID-19), the Rhode Island Department of Health will be relaxing regulatory enforcement for professional licensing by issuing temporary (90 day) licenses to those professionals listed on the cover page of this application.

There will be no cost to obtain the license or for the one-time renewal. This temporary license may be renewed one time. Professionals who wish to practice beyond the 180 days must fulfill all qualifications and requirements under the regulations for their profession.

Application Requirements

Completed Application
Verification of Active Out of State License

Application Requirements for Graduate Nurse (RN)

Completed Application
Verification from school of anticipated graduation date

Complete applications with required documentation can either be submitted by one of the following:

Mail: **Center for Professional Licensing**
Room 104 - 3 Capitol Hill
Providence, RI 02908-5097

Fax: 401-222-1272

Email: doh.elicense@health.ri.gov



State of Rhode Island and Providence Plantations Emergency 90 Day Temporary License By Reciprocity

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.

NOTE:
It is your responsibility to notify the Department of Health Board of any name changes.

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

First Name

Middle Name

Surname, (Last Name)

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

Maiden Name, 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.

No professional licensee's address (residence or business/employment) will be posted on the Department's Web site.

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

2nd 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

13. Affidavit of Applicant

Complete this section and sign.

Make sure that you 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 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 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 Department of Health 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)

NOTE: Applications Submitted without proper verification will be delayed.