



COMMONWEALTH OF VIRGINIA
 Department of Health Professions - Board of Nursing
 Perimeter Center
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FOR OFFICE USE ONLY

Fee Amount	Code	Approved	Date of Reinstatement

APPLICATION FOR REINSTATEMENT - REGISTERED NURSE

I hereby make application to reinstate my license as a **Registered Nurse** in the Commonwealth of Virginia. The following information in support of my application is submitted with a **check or money order** made payable to the *Treasurer of Virginia* in the amount of **\$225**. **The fees are non-refundable.**

Disclosure of Addresses

State law requires DHP to collect an official Address of Record from every healthcare professional licensed, registered, or certified by a health regulatory board. The Address of Record is the formal, official mailing address to which all business mail related to your license will be sent, including renewal notices, licenses, notices and orders issued by the boards, and other legal documents. Typically, licensees use their home address as their Address of Record. In most cases, it is permissible for you to provide an Address of Record other than your home address, such as a Post Office Box or a practice location. However, it must be a valid address served by the U.S. Postal Service.

Consistent with Virginia law and the mission of the Department of Health Professions, addresses of licensees are made available to the public. Normally, the Address of Record is the publically disclosable address. If you do not want your Address of Record to be made public, state law allows you to provide a second, publically disclosable address. Typically, this other address is the work or practice address. If you would like for your Address of Record to be made available to the public, complete both sections with the same address. If you provide us with a secondary address that is different than the Address of Record, the secondary address will be made available to the public and the Address of Record will not. **It is important to understand that nothing will be mailed to the secondary address by either the Department of Health Professions or the regulatory boards.**

APPLICANT - Please provide the information requested below and on all pages. (Print or Type)				
Use full name, not initials.				
Name: Last	First	Middle/Maiden		Suffix
Address of Record (Mailing Address)	City	State	Zip	Telephone Number
Publicly Disclosable Address	City	State	Zip	Telephone Number
Email Address			Fax Number	
Date of Birth / /	Social Security Number or Virginia DMV Control Number*			
Virginia RN License Number 0001-_____	Full Name at Time of Initial Licensure		Date First License Issued	

(If proof of name change to current name has not been filed with this office, submit a copy of the marriage certificate or court order authorizing the name change.)

* In accordance with §54.1-116 of the *Code of Virginia*, you are required to submit your Social Security Number or your Control Number issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded.

This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.

1. Please declare your primary state of residence: _____. (If not VA, please refer to Compact info on the instruction page.)
2. Please declare your state(s) of current practice: _____.
3. This question applies to any license or certificate as a registered nurse, licensed practical nurse, or nurse aide that may have been issued to you. Please answer **YES** or **NO** to *EACH* of the following: *(If you answer yes to any of the questions, please explain in detail below and have certified copies of any applicable orders sent directly to this office.)*
 - Have you ever had disciplinary action taken against your license to practice in a state or against your multi-state privilege to practice? YES _____ NO _____
 - Has any license issued to you ever been voluntarily surrendered? YES _____ NO _____
 - Have you ever had any of the following disciplinary actions taken against your license by any licensing authority in any jurisdiction: placed on probation, suspended, revoked or otherwise disciplined? YES _____ NO _____
 - Has your practice ever been the subject of an investigation by any licensing authority? YES _____ NO _____
 - Have you ever been denied a license or certification in a health related field or jurisdiction? YES _____ NO _____
4. Is your license in good standing in all jurisdictions where licensed? YES _____ NO _____ **(If no, explain below.)**
5. Please respond in full to the following questions. *You will need to provide documentation only if the response is different from that on your last application with this office. Please answer YES or NO to each question.*
 - Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence, but excluding traffic violations)? Yes _____ No _____. **If yes, explain below** and have a **certified copy** of the court order sent directly to the Board of Nursing.
 - Do you have a mental, physical or chemical dependency condition which could interfere with your current ability to practice nursing? Yes _____ No _____. **If yes, explain below** and have a letter from your treating licensed professional summarizing diagnosis, treatment and prognosis sent directly to the Board of Nursing.

EXPLANATIONS:

AFFIDAVIT
(To be completed before a Notary Public)

State of _____

County/City of _____

Name _____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a registered nurse in the Commonwealth of Virginia; that the statements herein contained are true in every respect; that he/she has complied with all requirements of the law; and that he/she has read and understands the affidavit.

Signature of Applicant

Subscribed to and sworn to before me this _____ day of _____, _____.

My commission expires on _____.

SEAL

Signature of Notary Public