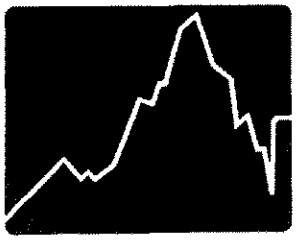

COMMONWEALTH OF VIRGINIA
Department of Health Professions - Board of Nursing
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804)367-4515 – PHONE (804) 527-4455 – FAX
web: **www.dhp.virginia.gov** email: nursebd@dhp.virginia.gov

APPLICATION FOR LICENSURE AS A NURSE PRACTITIONER

PLEASE CHECK: _____ Examination or _____ Endorsement

**I hereby make application for licensure as a Nurse Practitioner in the category of _____.
(See categories in the regulations.)

The following evidence of my qualifications is submitted with a **check or money order in the amount of **$125** made payable to the *Treasurer of Virginia.* **The application fee is non-refundable.**

Disclosure of Addresses

Some licensees have expressed concern that their residence address is accessible. Consistent with Virginia law and the mission of the Department of Health Professions addresses of licensees are made available to the public. This has been the policy and the practice of the Commonwealth for many years. However, the application of new technology makes such information more accessible.

In most cases it is permissible for an individual to provide an address of record other than a residence, such as a Post Office Box or a practice location. Changes of address may be made online, at the time of renewal, or at anytime by written notification to the appropriate health regulatory board on online at www.license.dhp.virginia.gov.
Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be mailed to the address provided.

APPLICANT - Please provide all information on this application.. (Print or Type)

Name: Last	Suffix	First	Middle	Maiden

Print your name as you wish it to appear on your license:

Street Address	Area Code & Telephone Number

City	State	Zip Code

Date of Birth (M/D/Y)	Social Security Number or Virginia DMV Control Number ***	Virginia RN License Number & Expiration Date

If you do not have a Virginia license, do you have a valid R.N. license in a compact state with a multi-state privilege?
YES _____ NO _____

If Yes, please list compact state, RN license number, and expiration date where you have been issued a multi-state privilege.

_____	_____	_____
State	RN License Number	Expiration Date

EDUCATION INFORMATION

Name of Nursing School	City, State or Province	Type of Program _____AD _____BS _____DIP
Program Completion Date:	Length of Program:	
Name of Master's/Graduate Degree Program	City, State or Province	Type of Program _____ MSN _____ Post Master's _____ Other
Program Completion Date:	Length of Program:	

Master's/Graduate Degree Program Accredited/Approved By: *(Accrediting Authority):*

_____

Professional Certification held from: *(Name of Organization)* _____

I **(am) (am not)** certified or registered with an equivalent title in another state.

Title: _____ State: _____

NP License Number: Date Certified or Registered: Current [ ] Lapsed [ ]

Prospective employer: _____

Address: _____

_____

Date you expect to begin employment as a Licensed Nurse Practitioner in Virginia: _____

Answer **YES** or **NO** to *EACH* of the following:

- 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 _____
- Have you ever been denied a license or certification in a health related field or jurisdiction? YES ____ NO ____
- Has any license issued to you been voluntarily surrendered? YES _____ NO _____
- Have you ever had any of the following disciplinary actions taken against your license or multi-state privilege 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 _____

If you answered yes to any of the above questions, please explain in detail by attaching a separate explanation sheet and have certified copies of any applicable orders sent directly to this office.

Answer **YES** or **NO** to *EACH* of the following:

Have you ever been licensed as a nurse practitioner in any state or province? Yes _____ No _____. If yes, is that license current _____? lapsed _____? inactive _____? If that license has been sanctioned, explain in detail by attaching a separate explanation sheet.

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 on a separate sheet 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 on a separate sheet and have a letter from your treating licensed professional summarizing diagnosis, treatment and prognosis sent directly to the Board of Nursing.

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 nurse practitioner 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

For Office Use Only	
Computer File Pending #	**Practitioner Type Code #**
Practitioner	**Date Issued**
Approved by: _____ **Board of Nursing**	

Revised 06/24/11

***** 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.