

**NORTH DAKOTA BOARD OF NURSING
INSTRUCTIONS FOR INITIAL ADVANCED PRACTICE LICENSE
with or without PRESCRIPTIVE AUTHORITY
INITIAL APPLICATION (SFN 16151)**

If you have never been licensed as an RN in North Dakota, you will also need to complete an “*Initial RN License by Endorsement*” online application unless you claim another compact state as your primary state of residence and currently hold a compact RN license from that compact state (**see compact information and primary state of residence information below). If you hold a current compact RN license in another state but will be changing your primary state of residence to ND when you come to work here you will still need to complete the “*Initial RN License by Endorsement*” online application.

For an up to date list of compact states please go to www.ncsbn.org.

**Primary State of Residence - Effective January 1, 2004 North Dakota joined the Nurse Licensure Compact along with several other states. The Nurse Licensure Compact states you must claim a primary state of residence. This state is referred to as your “home state” under the Nurse Licensure Compact and means that it is your “declared fixed permanent and principal home for legal purposes”. The Nurse Licensure Compact allows the multistate licensure privilege to practice in other compact states as an RN or LPN. The Advanced Practice license is not part of the Nurse Licensure Compact. For more information regarding the Nurse Licensure Compact visit the National Council State Boards of Nursing website at www.ncsbn.org.

54-05-03.1-02. Board authority - Title - Abbreviation. The board shall authorize advanced nursing practice to a registered nurse who has submitted evidence of advanced knowledge, skills, and abilities in a defined area of nursing practice. Individuals are licensed as advanced practice registered nurses in the roles of certified nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or certified clinical nurse specialist and in the population foci of family across the lifespan, adult-gerontology, neonatal, pediatrics, women’s health or gender related or psychiatric mental health. Each advanced practice registered nurse shall use the designation APRN and applicable role designation for purposes of identification and documentation. No person may use the advanced practice registered nurse (APRN) title plus the person’s respective role title without the express authority of the board of nursing to do so.

NDAC 54-05-03.1-04. INITIAL REQUIREMENTS FOR ADVANCED LICENSURE. Applicants for advanced practice registered nurse licensure must:

1. Possess or submit one of the following:
 - a. Have a current license to practice as a registered nurse in North Dakota. Make sure to include your current ND RN license number on the advanced practice application where indicated.
 - b. Have a current compact RN license in another compact state.
 - c. Submit an “Application for Registered Nurse License by Endorsement” if you do not currently have a ND RN license or an RN license from another compact state.
2. Submit evidence of completion of an accredited graduate level advanced practice registered nurse program in one of the four roles and with at least one population focus (official transcripts from program);
3. Submit evidence of current certification by a national nursing certifying body in the advanced practice registered nurse role and population foci appropriate to educational preparation. Primary source verification of certification is required;
4. Not have an encumbered license or privilege to practice in any state or territory;
5. Submit a completed “Initial Advanced Practice License with or without Prescriptive Authority” application and pay the appropriate fee.
6. Certify that scope of practice is consistent with their nursing education and nursing certification by checking the appropriate box on this application;
7. After December 31, 2015, all applicants for advanced practice registered nurse licensure must meet the licensure requirements in this chapter.
 - An applicant for licensure as an advanced practice registered nurse who completed an advanced nursing education program and was licensed or certified in advanced practice before December 31, 2015, may apply for and receive an advanced practice license if that applicant meets the requirements that were in effect at the time the applicant qualified for initial advanced practice licensure.
8. Complete a Criminal History Record Check (CHRC) per attached CHRC instructions.

54-05-03.1-06.2. Scope of Practice. Scope of practice of the advanced practice registered nurse must be consistent with the nursing education and nursing certification.

54-05-03.1-05. Temporary permit. An applicant for advanced licensure who possesses a current registered nurse license, and has submitted a complete application, the required fee, and evidence of meeting all educational requirements, may be issued a ninety-day temporary advanced practice registered nurse permit for practice in an advanced practice registered nurse category if the applicant:

1. Is applying for licensure under section 54-05-03.1-04;
2. Has applied as a first-time candidate to the next national nursing certification examination for the advanced practice registered nurse category;
3. Is awaiting certification results based upon initial application; or
4. Temporary permit will not include prescriptive authority.

The temporary permit will be listed on the ND Board of Nursing website at www.ndbon.org in the “Verify” section. No hard copy temporary permits will be issued. If the applicant fails the certification examination for which the applicant is eligible, the individual may no longer practice in the advanced practice registered nurse role.

LICENSE ISSUED:

1. For nurses claiming ND or a non-compact state as their primary state of residence:
The advanced practice registered nurse license category is included on the ND RN license. The advanced practice registered nurse license is renewed at the same time as the ND RN license. The license will be listed on the ND Board of Nursing website at www.ndbon.org in the "Verify Permits, Licenses, Registrations, Discipline History" section. No hard copy licenses will be issued.
2. For nurses claiming a compact state other than ND as their primary state of residence:
The advanced practice license is the only license you will receive. The ND Advanced Practice license will be listed on the ND Board of Nursing website at www.ndbon.org in the "Verify Permits, Licenses, Registrations, Discipline History" section. No hard copy licenses will be issued. Verification of your compact RN license must be done with the compact state you claim as your primary state of residence or on www.nursys.com

PRESCRIPTIVE AUTHORITY: An advanced practice registered nurse who desires to include prescriptive authority within the practitioner's scope of practice may apply for prescriptive authority for an additional fee of \$50.00 from the North Dakota Board of Nursing.

Prescriptive authority must be requested by the advanced practice registered nurse by completing the required portion of this application. The application process involves a review by board staff. When the application meets all the requirements established by the board the registered nurse/advanced practice license will be reissued with prescriptive authority.

54-05-03.1-09. Requirements for prescriptive authority. Applicants for prescriptive authority shall:

1. Be currently licensed or applying for licensure as an advanced practice registered nurse in North Dakota.
2. Submit a completed "Initial Advanced Practice License with or without Prescriptive Authority Application" and pay the fee of fifty dollars.
3. Submit a completed transcript with degree posted from an accredited graduate level advanced practice registered nurse program and which includes evidence of completion of advanced pharmacotherapy, physical assessment, and pathophysiology.
4. Provide evidence of completion of thirty contact hours of education or equivalent in pharmacotherapy related to the applicant's scope of advanced practice that:
 - a. Have been obtained within a three-year period of time immediately prior to the date of application for prescriptive authority;
 - or
 - b. May otherwise be approved by the board.

54-05-03.1-10. Authority to prescribe.

The advanced practice registered nurse plans and initiates a therapeutic regimen that includes ordering and prescribing medical devices and equipment, nutrition, diagnostic and supportive services including home health care, hospice, and physical and occupational therapy.

1. A permanent advanced practice registered nurse license with the addition of prescriptive authority shall be issued upon meeting all requirements.
2. The advanced practice registered nurse with prescriptive authority may prescribe drugs as defined by chapter 43-15-01 pursuant to applicable state and federal laws.
3. A prescriptive authority advanced practice registered nurse license does not include drug enforcement administration authority for prescribing controlled substances. Each licensee must apply for and receive a drug enforcement administration number before writing prescriptions for controlled substances.
4. An advanced practice registered nurse with prescriptive authority who prescribes controlled substances has access to the North Dakota prescription drug monitoring program and shall utilize the prescription drug monitoring program in the following manner:
 - a. Shall evaluate a prescription drug monitoring program report for a client in the following situations:
 - (1) New or unestablished client requiring prescription for controlled substance;
 - (2) Every six months during treatment of client with a controlled substance;
 - (3) Client requests early refills or engages in a pattern of taking more than prescribed dosage; and
 - (4) Upon suspicion or known drug overuse, diversion, or abuse by client.
 - b. Shall document evaluation of the prescription drug monitoring program reports made under this rule.
 - c. May evaluate the prescription drug monitoring program report in the following situations:
 - (1) Long-term care settings;
 - (2) Controlled settings in which controlled substances are locked and administered to client;
 - (3) Treatment of client with terminal illness, cancer, or cancer-related disorders; and
 - (4) Hospice or palliative care settings.
5. The licensee may prescribe, administer, sign for, dispense over-the-counter, legend, and controlled substances, and procure pharmaceuticals, including samples following state and federal regulations.
6. The signature on documents related to prescriptive practices must clearly indicate that the licensee is an advanced practice registered nurse.
7. The advanced practice registered nurse with prescriptive authority may not prescribe, sell, administer, distribute, or give to oneself or to one's spouse or child any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug.
8. Notwithstanding any other provision, a practitioner who diagnoses a sexually transmitted disease, such as chlamydia, gonorrhea, or any other sexually transmitted infection, in an individual patient may prescribe or dispense, and a pharmacist may dispense, prescription antibiotic drugs to that patient's sexual partner or partners, without there having been an examination of that patient's sexual partner or partners.

LICENSE ISSUED: Prescriptive authority will be indicated along with the agreed upon advanced practice category. The license will be listed on the ND Board of Nursing website at www.ndbon.org in the "Verify Permits, Licenses, Registrations, Discipline History" section. No hard copy licenses will be issued. Advanced Practice License expiration dates are the same as the ND RN license as they are the same license number.



INITIAL ADVANCED PRACTICE APPLICATION
with or without PRESCRIPTIVE AUTHORITY
 NORTH DAKOTA BOARD OF NURSING
 SFN 16151 (12-18)

FOR OFFICE USE ONLY	
Fee Received:	<input type="checkbox"/> Nursys
<input type="checkbox"/> DRP	<input type="checkbox"/> Disc Review
<input type="checkbox"/> AP Temp Permit	
<input type="checkbox"/> AP Full License	<input type="checkbox"/> RX Full License
APRN Title	

PERSONAL INFORMATION

Last Name		First Name		Middle Name	
Maiden Name (If Married)		Mother's Maiden Name		*Social Security Number	
Address		City		State	ZIP Code
County		ND RN License Number (if applicable)		Date of Birth	
Email address		Home Telephone Number		Work Telephone Number	
For Statistical Purposes <input type="checkbox"/> Male <input type="checkbox"/> Female		Primary Language Code <input type="checkbox"/> English <input type="checkbox"/> English and Another Language <input type="checkbox"/> Another Language			
ETHNIC INFORMATION <input type="checkbox"/> African American <input type="checkbox"/> Native American		<input type="checkbox"/> Hispanic <input type="checkbox"/> Asian Other		<input type="checkbox"/> White-Not of Hispanic Origin <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other	

*In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to North Dakota Century Code 43-50-02. The individual's social security number is used for identification purposes.

NURSE LICENSURE COMPACT INFORMATION – DECLARATION OF PRIMARY STATE OF RESIDENCE

Primary state of residence is where you hold a driver's license, pay taxes, and/or vote. This state is referred to as your "home state" under the Nurse Licensure Compact and means that it is your "declared fixed permanent and principal home for legal purposes". If your primary state of residence is a compact state, you must have a current compact RN license in that compact state. For an up to date list of compact states please go to www.ncsbn.org.

I declare my primary state of residence to be		
RN License Number in my compact primary state of residence (if applicable):		
RN license in my compact primary state of residence will expire (if applicable)		
Will you be changing your primary state of residence to North Dakota when you come to work in ND?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If you answered "yes" to the above question, what date will ND become your primary state of residence?		

RN LICENSURE INFORMATION (list ALL STATES in which you are/have been licensed as an RN- attach another sheet if necessary)

Original State of Licensure	Year Licensed	Name in which license was issued	License Number	Status of Licensure <input type="checkbox"/> Active <input type="checkbox"/> Inactive/Lapsed
Other States where Licensed	Year Licensed	Name in which license was issued	License Number	Status of Licensure <input type="checkbox"/> Active <input type="checkbox"/> Inactive/Lapsed
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive/Lapsed
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive/Lapsed

APRN LICENSURE BY ANOTHER STATE

STATE	INITIAL LICENSE DATE	STATE	INITIAL LICENSE DATE	STATE	INITIAL LICENSE DATE
Have you ever had approval to practice in an advanced role denied, limited, suspended, or revoked? If yes, attach a letter of explanation to this application.				<input type="checkbox"/> NO	<input type="checkbox"/> YES

BASIC NURSING PREPARATION (list complete information for basic RN nursing program)

Name of College/School of Nursing				
Address		City	State	ZIP Code
Certificate/Degree Granted <input type="checkbox"/> Diploma(RN) <input type="checkbox"/> Associate Degree(RN) <input type="checkbox"/> Baccalaureate		Entry Date	Completion Date	

ADVANCED PREPARATION

School/Institution		Name of Program					
Address		City	State	ZIP Code			
Date of Entry	Date of Completion	Credential Awarded					
<p>APRN Roles</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> NP (choose specialty below) <input type="checkbox"/> Adult <input type="checkbox"/> Family <input type="checkbox"/> Gerontology <input type="checkbox"/> Neonatal <input type="checkbox"/> Pediatric <input type="checkbox"/> Psychiatric <input type="checkbox"/> Women's Health Care </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> CNS (choose specialty below) <input type="checkbox"/> Adult <input type="checkbox"/> Gerontology <input type="checkbox"/> Child/Adolescent Psychiatric <input type="checkbox"/> Adult Psychiatric </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> CRNA <input type="checkbox"/> CNM </td> </tr> </table>					<input type="checkbox"/> NP (choose specialty below) <input type="checkbox"/> Adult <input type="checkbox"/> Family <input type="checkbox"/> Gerontology <input type="checkbox"/> Neonatal <input type="checkbox"/> Pediatric <input type="checkbox"/> Psychiatric <input type="checkbox"/> Women's Health Care	<input type="checkbox"/> CNS (choose specialty below) <input type="checkbox"/> Adult <input type="checkbox"/> Gerontology <input type="checkbox"/> Child/Adolescent Psychiatric <input type="checkbox"/> Adult Psychiatric	<input type="checkbox"/> CRNA <input type="checkbox"/> CNM
<input type="checkbox"/> NP (choose specialty below) <input type="checkbox"/> Adult <input type="checkbox"/> Family <input type="checkbox"/> Gerontology <input type="checkbox"/> Neonatal <input type="checkbox"/> Pediatric <input type="checkbox"/> Psychiatric <input type="checkbox"/> Women's Health Care	<input type="checkbox"/> CNS (choose specialty below) <input type="checkbox"/> Adult <input type="checkbox"/> Gerontology <input type="checkbox"/> Child/Adolescent Psychiatric <input type="checkbox"/> Adult Psychiatric	<input type="checkbox"/> CRNA <input type="checkbox"/> CNM					

CERTIFICATION – (verification must be submitted directly from certification organization)

Name of Certifying Organization			Certificate Number	
Address		City	State	ZIP Code
Date of Original Certification	Date Scheduled for Examination	Expiration Date of Current Certification		

SCOPE OF PRACTICE VERIFICATION (please read and certify by checking the box for your application to be processed)

<input type="checkbox"/> I certify that my scope of practice is consistent with my education, certification and NDAC Section 54-05-03.1-03.2.

REGULATORY QUESTIONS - ALL QUESTIONS MUST BE COMPLETED

1.	Have you ever been convicted, entered a plea of guilty, nolo contendere, or no contest, for any felony or misdemeanor offense(s)? Must Answer YES if: A conviction has been pardoned, dismissed, expunged, sealed, stayed, deferred, or suspended; or If you have entered into any agreement by which an offense would be dismissed upon completion of certain terms.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Are there any pending charges against you with respect to a felony or misdemeanor offense?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	Have you had an unlicensed assistive person registry or nurse aide registry listing marked for abuse, neglect or misappropriation of property?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.	Has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.	Have you been investigated or are you presently being investigated by any other jurisdiction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6.	Have you been denied registration or nursing licensure by any other jurisdiction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7.	Have you been terminated from a nursing related job due to conduct that may be grounds for disciplinary action?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	Do you currently have a diagnosis of chemical dependency or are you participating in chemical dependency treatment/rehabilitation or an alternative to discipline/monitoring program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9.	Are you currently experiencing a physical, emotional, or mental condition that may impair your ability to practice nursing with reasonable skill and safety?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If your answer is "YES" to any question above, attach a detailed written explanation and related legal documents to the application and send to the board.

EMPLOYMENT INFORMATION -List all past employment as a nurse during the past four years, starting with your most recent employer.

PRACTICE YEAR	NURSING PRACTICE YES (Y) NO (N)	HOURS PRACTICED IN NURSING EACH YEAR	PLACE OF NURSING PRACTICE (NAME OF AGENCY, CITY, STATE)	POSITION IN NURSING
2018	<input type="checkbox"/> Y <input type="checkbox"/> N			
2017	<input type="checkbox"/> Y <input type="checkbox"/> N			
2016	<input type="checkbox"/> Y <input type="checkbox"/> N			
2015	<input type="checkbox"/> Y <input type="checkbox"/> N			
2014	<input type="checkbox"/> Y <input type="checkbox"/> N			

ND PRACTICE

Name of ND Institution/Clinical Facility			Start Date
Address	City	State	ZIP Code

****PLEASE NOTE THAT YOU MAY NOT BEGIN PRACTICE AS AN APRN UNTIL YOU HAVE RECEIVED THE TEMPORARY PERMIT OR LICENSE FROM THE NORTH DAKOTA BOARD OF NURSING. "PRACTICE/EMPLOYMENT" DOES INCLUDE ORIENTATION.**

CRIMINAL HISTORY RECORD CHECK (CHRC)

1. Have you completed a Criminal History Record Check for the ND Board of Nursing in the past 90 days?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you answered "Yes" to the above question #1, what was the month and year of completion of the CHRC?	Month	Year

If you answered "No" to the above question #1, you must submit to a Criminal History Record Check by checking below, including an additional \$20 processing fee with this application, completing the attached Criminal History Record Check Process by following the CHRC Instructions.

As part of this application process, I agree to submit to a Criminal History Record Check.

A nonrenewable temporary permit will be issued to applicants that have met all other requirements for licensure or registration and have agreed to submit to a criminal history record check according to NDCC 43-12.1-09.1. The temporary permit will be listed on the ND Board of Nursing website at www.ndbon.org in the "Verify" section. No hard copy temporary permits will be issued.

PRESCRIPTIVE AUTHORITY

As part of this application process, I am applying for Prescriptive Authority and will include an additional \$50 nonrefundable fee.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I certify that I will utilize the Prescription Drug Monitoring Program (PDMP) consistent with ND Administrative Code 54-05-03.1-10 (4)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

EDUCATIONAL EXPERIENCE IN PHARMACOTHERAPY

- A minimum of thirty contact hours or equivalent of pharmacotherapy **completed in the last three years** are required for initial prescriptive authority.
- Pharmacotherapy in the design, implementation, and monitoring of drug (pharmaceutical) therapy using specialized knowledge of pharmacokinetics, pharmacology, pathophysiology, and therapeutics.
- **ATTACH COPIES OF PHARMACOTHERAPY SPECIFIC CERTIFICATES OF CONTACT HOURS COMPLETED IN THE PAST THREE (3) YEARS. (not attaching these certificates when applying for prescriptive authority will delay the issuance of your license)**
- **Only certificates which itemize pharmacology CE will be accepted. UpToDate activity certificates do NOT meet the requirement for pharmacology specific CE.**

CE COMPARISON

- 1 Contact Hour = 60 Minutes
- 1.2 Contact Hours = 60 Minutes = 1 CME
- 10 Contact Hours = 1 CEU
- 15 Contact Hours = 1 Semester Academic Credit

APPLICANT CERTIFICATION (signature and date required for application to be processed)

I certify the information provided is true, correct, and complete, and I understand that submission of any false or incomplete information may be grounds for disciplinary action.
 I agree that all licensure information may be submitted by law to Nursys, a national nurse licensure databank.
 I understand that a full license will not be issued until all CHRC requirements are met.

Applicant Signature	Date
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SEND APPLICATION WITH THE FOLLOWING

- EVIDENCE OF CURRENT CERTIFICATION FROM CERTIFICATION ORGANIZATION**
- OFFICIAL TRANSCRIPT**
- \$100 NONREFUNDABLE APPLICATION FEE**
- \$50 NONREFUNDABLE PRESCRIPTIVE AUTHORITY FEE (if you are also applying for Prescriptive Authority)**
- \$20 NONREFUNDABLE PROCESSING FEE (If you answered "no" to the CHRC question)**
- THE CHRC form & fingerprint cards listed in CHRC instructions (If you answered "no" to the CHRC question).**

NORTH DAKOTA BOARD OF NURSING
 919 S 7th STREET, SUITE 504
 BISMARCK, ND 58504-5881

FOR OFFICE USE ONLY

ND License Number
Compact State
Compact RN License Number
Discipline History
Basic Nursing Preparation
AP Program & Completion Date
APRN Type
Certification Program & Expiration Date
<input type="checkbox"/> CHRC
<input type="checkbox"/> Certification Statement checked
<input type="checkbox"/> Pharmacotherapy 30 contact hrs



**VERIFICATION OF PROGRAM COMPLETION ADVANCED PRACTICE
REGISTERED NURSE
NORTH DAKOTA BOARD OF NURSING**

- Only to be completed by a new graduate whose graduate degree has yet to be posted on the official transcript.

Applicant – Complete sections A and B; then attach the completed Request for Transcript form and send to your education program for completion ("Request for Release of Transcript" is on www.ndbon.org - choose Nurse Licensure/Advanced Practice Licensure/Initial License Requirements).

A.

Education Program			
Education Program Address	City	State	ZIP Code

B.

Name of Applicant			
Address	City	State	ZIP Code
Name of Program			
Program Location	Year Completed		

VERIFICATION (to be completed by Program Director)

C.

Name of Advanced Formal Nursing Education Program			
Address	City	State	ZIP Code
Inclusive Dates of Attendance			
Certificate or degree awarded that prepares for advanced practice			
Accredited By (Name of National Accrediting Agency)			

Program Director Signature	Date Verified
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RETURN TO

**North Dakota Board of Nursing
919 S 7th St, Suite 504
Bismarck, ND 58504-5881
(701) 328-9777**

CRIMINAL HISTORY RECORD CHECK (CHRC) INSTRUCTIONS

1. Submit an online RN or LPN initial application by exam or endorsement OR include one of the following forms:
 - An RN or LPN Reactivation Form or;
 - An initial APRN application or;
 - A UAP/Technician/MAIII initial or reactivation form
1. Contact your local law enforcement agency or a private agency that provides fingerprinting services to make an appointment to be fingerprinted.
 - a. Fee for fingerprinting will vary depending upon agency charges.
 - Agencies and law enforcement are to use the standard FBI Applicant card (FD-258) for fingerprints.
2. Submit the following to North Dakota Board of Nursing (NDBON) - address is at bottom of this form:
 - Criminal History Record Check form at:
<https://attorneygeneral.nd.gov/sites/ag/files/documents/CHR-Request-SFN60688.pdf> - Complete the last section titled "To be Completed by Subject of Record Check" only. Also sign and date form.
 - Completed fingerprint cards (from the law enforcement agency/private agency)
 - TWO completed fingerprint cards if ink and roll
 - ONE completed fingerprint card if electronic
 - Do not fold fingerprint cards
 - Money Order or Cashier Check for **\$41.25**, with a **current date**, and must be made **PAYABLE TO BCI**.
(No personal checks accepted)
3. NDBON will submit the completed form, fee, and fingerprint cards to Bureau of Criminal Investigations (BCI).
 - BCI will return the background check results to NDBON.
 - If fingerprints are rejected by BCI, NDBON will notify you.

Required fields to be completed at the top of the fingerprint card using BLACK ink:

- ❖ Last Name, First Name, Middle Name
- ❖ Signature of Person Fingerprinted (Your Signature)
- ❖ Aliases/AKA (**Do Not Leave Blank**)
 - Maiden name
 - Other names used by you
 - **Insert N/A if you have none**
- ❖ Date of Birth (MM/DD/YYYY format)
- ❖ Residence of Person Fingerprinted (Your physical residence address NOT mailing address)
- ❖ Citizenship (US or other country)
- ❖ Sex (M for male; F for female)
- ❖ Race
 - A - Asian/Pacific Islander
 - B – Black/African American
 - I - American Indian or Alaskan Native
 - W - White or Hispanic
 - U - Unknown
- ❖ Height (Enter in feet & inches. Examples-if 5 feet 7 inches tall enter 507; if 5 feet 10 inches tall enter 510)
- ❖ Weight (in pounds)
- ❖ Eyes (color- use code from color code box below)
- ❖ Hair (color- use coed from color code box below)
- ❖ Place of birth (If in US, use 2 letter state abbreviation. If foreign country, enter full name)
- ❖ Date (date prints taken)
- ❖ Signature of Official Taking fingerprints
- ❖ Social Security Number (Use XXX-XX-XXX format)

If fingerprint cards are incomplete you will be required to submit new cards

North Dakota Board of Nursing
919 S 7th St, Suite 504
Bismarck, ND 58504-5881
Telephone: 701-328-9780

Reviewed/Revised: 12/18

Eye and Hair Color Codes

BLK	Black	GRY	Gray	GRN	Green
BRO	Brown	HAZ	Hazel	MUL	Multi-colored
BLN	Blond or Strawberry	WHI	White	SDY	Sandy
RED	Red or Auburn	BLD	Bald	MAR	Maroon
PNK	Pink	BLU	Blue	ONG	Orange
PLE	Purple				