



**SPECIALTY PRACTICE REGISTERED NURSE
INITIAL APPLICATION**
NORTH DAKOTA BOARD OF NURSING
SFN 53333 (12-18)

FOR OFFICE USE ONLY	
APPROVAL	PERMIT INFO
<input type="checkbox"/> Nursys	Permit Number
<input type="checkbox"/> Temp Permit	Date Issued
<input type="checkbox"/> Full License	Date Expired
<input type="checkbox"/> DRP	Fee Received
<input type="checkbox"/> Disc Review	SPRN Title
Permanent License Issue Date	

DEFINITION: "Specialty practice registered nurse" means a person who holds a current license to practice in this state as a specialty practice registered nurse and has the educational preparation and national certification within a defined area of nursing practice.

NDAC 54-05-03.2-04. INITIAL REQUIREMENTS FOR SPECIALTY PRACTICE LICENSURE. Applicants for specialty 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 specialty practice application where indicated; or
 - b. Have a current compact RN license in another compact state; or
 - c. Submit an "Initial RN or LPN License by Endorsement" if you do not currently have a ND RN license or an RN license from another compact state. You may find this application on our website at www.ndbon.org – choose Initial RN or LPN License by Endorsement under Nurse Licensure.
2. Submit evidence of experiential expertise gained through the clinical aspect of coursework or employment; and/or
3. Submit evidence of additional educational preparation in continuing education programs or formal education in a board approved program; and
4. Submit evidence of current certification by a national certifying body in the specific area of nursing practice; and
5. Submit a completed application and pay the fee of one hundred dollars; and
6. Submit a scope of practice statement for review and approval by the board and
7. Submit other activities as approved by the board
8. Complete a Criminal History Record Check. The North Dakota Board of Nursing (NDBON) is responsible for coordinating the Federal Bureau of Investigations (FBI) background checks with the Bureau of Criminal Investigations (BCI) division of the State Attorney General. **Complete and sign the attached Criminal History Record Check (CHRC) Form and include a \$20 processing fee if you have not completed a Criminal History Record Check for the ND Board of Nursing in the past 90 days. Then follow the CHRC Instructions to complete the CHRC process.**

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"/> White-Not of Hispanic Origin <input type="checkbox"/> Asian Other <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?		

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.

BASIC NURSING PREPARATION (list complete information for basic 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

SPECIALTY PREPARATION

School/Institution		Name of Program	
Address		City	State Zip Code
Date of Entry	Date of Completion	Credential Awarded	
SPRN category <input type="checkbox"/> CRNFA <input type="checkbox"/> CET <input type="checkbox"/> CDE <input type="checkbox"/> OTHER (specialty)_____			

CERTIFICATION

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

LIST ALL OTHER STATES YOU HAVE EVER HELD AN RN LICENSE

ACTIVE LICENSES	
INACTIVE LICENSES	

LIST ALL OTHER STATES YOU HAVE EVER HELD AN SPRN LICENSE

ACTIVE LICENSES	
INACTIVE LICENSES	

Have you ever had approval to practice in a specialty role denied, limited, suspended, or revoked? If yes, attach a letter of explanation to this application.	<input type="checkbox"/> NO	<input type="checkbox"/> YES
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LIST ALL STATES YOU ARE CURRENTLY PRACTICING IN	SINCE YOUR LAST RENEWAL, WHAT STATES DID YOU PRACTICE IN?

EMPLOYMENT INFORMATION -List all past employment as a nurse during the past four years, starting with your most recent employer. If employed part time, you must list the number of hours employed.

PRACTICE YEAR	HOURS PRACTICED IN NURSING EACH YEAR	PLACE OF NURSING PRACTICE (NAME OF AGENCY, CITY, STATE)	NURSING POSITION
2018			
2017			
2016			
2015			

ND PRACTICE SETTING

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

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
<p>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 Criminal History Record Check Process by following the attached CHRC Instructions.</p> <p><input type="checkbox"/> As part of this application process, I agree to submit to a Criminal History Record Check.</p>		
<p>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.</p>		

APPLICANT CERTIFICATION

<p>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.</p>	
Applicant Signature	Date

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

SEND APPLICATION WITH THE FOLLOWING

1. SCOPE OF PRACTICE
2. COPY OF CURRENT CERTIFICATION
3. OFFICIAL TRANSCRIPT
4. \$100 NONREFUNDABLE APPLICATION FEE
5. \$20 NONREFUNDABLE PROCESSING FEE (If you answered "no" to the CHRC question)
6. THE CHRC FORM AND FINGERPRINT CARDS AS LISTED IN ATTACHED CHRC INSTRUCTIONS (If you answered "no" to the CHRC question)

FOLLOW THE CHRC INSTRUCTIONS TO COMPLETE THE CRIMINAL HISTORY RECORD CHECK

NORTH DAKOTA BOARD OF NURSING
 919 S 7th STREET, SUITE 504
 BISMARCK, ND 58504-5881
 Phone (701) 328-9777; Web Site www.ndbon.org



**SPECIALTY PRACTICE REGISTERED NURSE
SCOPE OF PRACTICE
NORTH DAKOTA BOARD OF NURSING**

Scope of Practice is the delineation of the applicant's practice which identifies the nature and extent of the applicant's practice and includes 1) focus of care, 2) elements of care, 3) type of client, and 4) consultation patterns with members of the health care team.

SCOPE OF PRACTICE STATEMENT: The scope of practice statement is submitted for review and approval for initial licensure, and for biennial renewal. You must also submit a revised scope of practice statement if there is any change in the employment status, practice setting, or scope of practice. It is the licensee's responsibility to make sure the scope of practice statement on file in the board office reflects current practice.

The scope of practice for a registered nurse with specialty licensure is based upon an understanding that a broad range of health care services can be appropriately and competently provided by a registered nurse with validated knowledge, skills, and abilities in specific practice areas. The health care needs of citizens in North Dakota require that nurses in specialty practice roles provide care to the fullest extent of their scope of practice. The specialty practice registered nurse retains the responsibility and accountability for that scope of practice and is ultimately accountable to the client within the Nurse Practices Act.

NORTH DAKOTA BOARD OF NURSING
919 S 7TH ST., SUITE 504
BISMARCK ND 58504-5881
(701) 328-9777

Signature _____

Date _____

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
2. Contact your local law enforcement agency or a private agency that provides fingerprinting services to make an appointment to be fingerprinted.
 - 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.
3. 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)**
4. 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				