2021-2022 TWO YEAR LICENSE RENEWAL ADVANCED PRACTICE WITH or WITHOUT PRESCRIPTIVE AUTHORITY

NORTH DAKOTA BOARD OF NURSING

SFN 58481 (06-22)

Last Name	First Name	Middle Name	
Address		ND RN/APRN License Number	
City		State	ZIP Code
County	*Social Security Number	Birth Date	
Email Address	Home Telephone Number	Work Telephone Number	

APRN Roles

☐ NP (choose specialty below)
- ☐ Adult
- ☐ Family
- ☐ Gerontology
- ☐ Neonatal
- ☐ Pediatric
- ☐ Psychiatric
- ☐ Women's Health Care

☐ CNS (choose specialty below)
- ☐ Adult
- ☐ Gerontology
- ☐ Child/Adolescent Psychiatric
- ☐ Adult Psychiatric

☐ CRNA

☐ CNM

APRN Certifying Agency	**Certifying Agency Certificate Number**	**Expiration Date**

*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. Failure to provide the social security number will cause the application to not be processed.

SCOPE OF PRACTICE VERIFICATION (both statements must be read and checked for your application to be complete)

☐ I certify that my scope of practice is consistent with my education, certification and NDAC Section 54-05-03.1-03.2.

PRESCRIPTIVE AUTHORITY

I am also renewing my Prescriptive Authority and will include the appropriate fee.	☐ YES	☐ NO

CONTINUING EDUCATION FOR PRESCRIPTIVE AUTHORITY (if applicable)

☐ I verify that I have completed 15 contact hours of continuing education or 1 semester hour of academic credit that:

1. has been obtained during the previous two years prior to renewal
2. is pharmacotherapy content related to the scope of practice
3. these contact hours may fulfill the registered nurse/APRN renewal continuing education requirement listed above. The education or its equivalent as approved by the board may include academic credits, attendance at approved seminars, and courses or participation in approved correspondence or home study continuing education courses.

Retain all continuing education records in your personal file for at least four years. Do not submit to the board office unless you receive a Notice of Audit from the Board office.

PRESCRIPTION DRUG MONITORING UTILIZATION CERTIFICATION

I certify that I will utilize the Prescription Drug Monitoring Program (PDMP) consistent with ND Administrative Code 54-05-03.1-10 (4)	☐ YES	☐ NO

APPLICANT CERTIFICATION (check each box to verify you have read and attest to the statement)

☐ I acknowledge that this form is a legal document.

☐ I understand that no one else may submit this form on my behalf and that I am accountable and responsible for the accuracy of any answer or statement on this form.

☐ I certify that the information provided is true, correct, and complete.

☐ I attest that I meet all the requirements to practice for the type of licensure requested, as listed in NDAC 54-02-06.	
☐ I understand that submission of any false or incomplete information is a violation of NDCC 43-12.1-14 and 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 (if applicable).	
Applicant Signature	Date

EMAIL RENEWAL@NDBON.ORG TO OBTAIN AN INVOICE NUMBER TO PAY THE PROPER FEE AS SOON AS FORM IS EMAILED OR FAXED TO ND BOARD OF NURSING
(FEE IS DOUBLE WHEN PAYING AFTER DECEMBER 31):
ADVANCED PRACTICE REGISTERED NURSE $80.00;
ADVANCED PRACTICE REGISTERED NURSE WITH PRESCRIPTIVE AUTHORITY $155.00.

NORTH DAKOTA BOARD OF NURSING
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BISMARCK, ND 58504-5881
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WEBSITE: www.ndbon.org