# 2019-2020 TWO YEAR RN/LPN LICENSE RENEWAL APPLICATION

NORTH DAKOTA BOARD OF NURSING

SFN 52123 (12-18)

| FOR OFFICE USE ONLY | |
|---|---|
| Date Received | |
| Fee | Approval |
| Discipline | DRP |
| Full License | Verif. form sent |
| Date Issued | |

| |
|---|
| First Name |
| Last Name |
| North Dakota RN/LPN License Number |

**ENCLOSE PROPER FEE-(double the amount below for a late renewal):**

**LICENSED PRACTICAL NURSE $110**

**REGISTERED NURSE $120**

## ALL QUESTIONS / SECTIONS MUST BE COMPLETED- incomplete applications will be returned

**DEMOGRAPHIC INFORMATION**

| | | |
|---|---|---|
| *Social Security Number | | Address |
| Licensee Home Telephone Number | | City |
| Licensee Work Telephone Number | | State |
| Email address | Date of Birth | Zip Code |
| Mother's Maiden Name | | County |

*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**

**Primary state of residence is where you hold a driver's license, pay taxes, and/or vote. This state is referred to as my "home state" under the Nurse Licensure Compact and means that it is my "declared fixed permanent and principal home for legal purposes".**

I declare my primary state of residence to be _____

**ARMED SERVICES OR FEDERAL EMPLOYEE INFORMATION**

| | | | | | |
|---|---|---|---|---|---|
| Are you practicing in a military capacity? | Yes ☐ | No ☐ | Are you practicing in a federal institution? | Yes ☐ | No ☐ |

**LIST ALL OTHER STATES YOU HAVE EVER HELD LICENSES**

| | |
|---|---|
| **ACTIVE LICENSES** | |
| **INACTIVE LICENSES** | |

| **LIST ALL STATES YOU ARE CURRENTLY PRACTICING IN** | **SINCE YOUR LAST RENEWAL, WHAT STATES DID YOU PRACTICE IN?** |
|---|---|
| | |

**HIGHEST EDUCATION COMPLETED**

| | | | |
|---|---|---|---|
| ☐ Vocational Certificate (LPN/VN) | ☐ Diploma (RN) | ☐ Master's Degree (Nursing) | ☐ Doctorate Degree (Nursing) |
| ☐ Associate Degree (LPN) | ☐ Associate Degree (RN) | ☐ Master's Degree (Other) | ☐ Doctorate Degree (Other) |
| | ☐ Bachelor's Degree (Nursing) | | |
| | ☐ Bachelor's Degree (Other) | | ☐ Advanced Practice Post Basic Education |

**CONTINUING EDUCATION (must answer one of the following questions)**

| | | |
|---|---|---|
| 1. I certify that I have completed 12 contact hours of Continuing Education in the past two years and will retain the CE records for the next 4 years. | Yes ☐ | No ☐ |
| 2. I certify that I was just licensed by exam in North Dakota in 2017 or 2018. | Yes ☐ | No ☐ |

**LIST ALL NURSING EMPLOYMENT IN THE PAST 2 YEARS**

| PRACTICE YEAR | NURSING PRACTICE EMPLOYER NAME(S) | NUMBER OF NURSING POSITIONS HELD | CITY AND STATE OF NURSING PRACTICE | HOURS PRACTICED IN NURSING EACH YEAR |
|---|---|---|---|---|
| 2018 | | | | |
| 2017 | | | | |

**COMPLETE THE MOST APPLICABLE CHOICE FROM EACH CATEGORY**

| EMPLOYMENT SETTING FOR PRINCIPAL NURSING POSITION | MAJOR CLINICAL PRACTICE OR TEACHING AREA |
|---|---|
| _ Ambulatory Care Clinic<br>Church<br>Government<br>Home Health<br>Hospital<br>Military<br>_ Nursing Education Program<br>_ Nursing Home/ Extended Care<br>_ Occupational Health<br>Physician's Office<br>_ Public/Community Health<br>School Health Services<br>_ Self Employed<br>Social/Human Services<br>Temporary Agency<br>_ Other (Please specify)_____ | ☐ Anesthesia<br>Chemical Dependency<br>_ Critical Care<br>Emergency Care<br>Family Practice<br>_ Geriatrics<br>_ Home Health<br>_ Maternal/Child Health<br>_ Medical/Surgical<br>Mental Health<br>_ Neonatology<br>_ Nursing Administration<br>_ Oncology<br>_ Parish<br>_ Pediatrics<br>_ Perioperative<br>_ Public/Community Health<br>_ Quality Assurance<br>_ Rehabilitation<br>_ School<br>_ Other (Please specify)_____ |

| TYPE OF PRINCIPAL NURSING POSITION | EMPLOYMENT STATUS | IF YOU ARE UNEMPLOYED WHAT IS YOUR REASON FOR BEING UNEMPLOYED? |
|---|---|---|
| Advanced Practice Registered Nurse<br>_ Nurse Administrator<br>_ Nurse Consultant<br>Nurse Educator<br>Nursing Faculty in College of Nursing<br>_ Nursing Manager<br>_ Office Nurse<br>Specialty Practice Registered Nurse<br>_ Staff Nurse<br>_ Travel Nurse<br>_ Other (Please specify)_____ | Full Time<br>_ Not Employed<br>_ Nursing Volunteer<br>Part Time<br>Per diem<br>_ Retired | _ Caring for Home and Family<br>_ Difficulty Finding Position<br>Disabled<br>_ Inadequate salary<br>Other _____<br>School |

**ALL QUESTIONS MUST BE COMPLETED**

| | | | |
|---|---|---|---|
| 1. | Since you last renewed your ND license, have you been convicted, entered a plea of guilty, nolo contendere, or no contest, for any felony or misdemeanor offense(s)?<br>Must Answer YES if:<br>A conviction has been pardoned, dismissed, expunged, sealed, stayed, deferred, or suspended; or<br>If you have entered into any agreement by which an offense would be dismissed upon completion of certain terms. | YES | NO |
| 2. | Are there any pending charges against you with respect to a felony or misdemeanor offense? | YES | NO |
| 3. | Since you last renewed your ND license, have you had an unlicensed assistive person registry or nurse aide registry listing marked for abuse, neglect or misappropriation of property? | YES | NO |
| 4. | Since you last renewed your ND license, has your registration or nursing license been sanctioned or disciplined by any other jurisdiction? | YES | NO |
| 5. | Since you last renewed your ND license, have you been investigated or are you presently being investigated by any other jurisdiction? | YES | NO |
| 6. | Since you last renewed your ND license, have you been denied registration or nursing licensure by any other jurisdiction? | YES | NO |
| 7. | Since you last renewed your ND license, have you been terminated from a nursing related job due to conduct that may be grounds for disciplinary action? | YES | 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? | YES | 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? | YES | NO |

If your answer is "YES" to any of the above questions, attach a detailed written explanation and related legal documents to the application. This information will be reviewed by the board's Disciplinary Review Panel.

I certify the information provided is true, correct, and complete, and I understand that submission of any false or undisclosed 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.

| Signature | Date |
|---|---|
| | |

**This form is to be used in January 2019 and is only for nurses whose license expired 12/31/2018. This form must be completed and in the Board office no later than 12:00pm CST, January 31, 2019. Have your employer complete the Verification of Practice form.**
**If your license expired prior to 12/31/2018 use the Reactivation Form available on the ND Board of Nursing website.**

You may not practice as a nurse until your forms have been received in the board office, payment has been made, and your updated license expiration date displays on the board's website at www.ndbon.org under "verify".

1. ANY RENEWAL APPLICATION FOR A 2019-2020 LICENSE RECEIVED IN THE BOARD OFFICE **AFTER DECEMBER 31, 2018**, WILL NEED TO PAY **DOUBLE THE RENEWAL FEE** AND PROVIDE **PROOF THAT THE APPLICANT HAS NOT PRACTICED NURSING AFTER DECEMBER 31, 2018 by completing a Verification of Practice form.** **All *online renewals must be completed online no later than December 31, 2018.***

2. **ENCLOSE PROPER FEE (DOUBLE THE FEE BELOW WHEN PAYING AFTER DECEMBER 31, 2018):**
   LICENSED PRACTICAL NURSE $110.00;
   REGISTERED NURSE $120.00;
   ADVANCED PRACTICE REGISTERED NURSE $160.00;
   ADVANCED PRACTICE REGISTERED NURSE WITH PRESCRIPTIVE AUTHORITY $210.00.

3. **RETURN TO:** FAX RENEWAL FORM AND VERIFICATION OF PRACTICE FORM TO (701) 328-9785; AFTER YOU HAVE FAXED FORM CALL (701) 328-9788 TO MAKE PAYMENT WITH CREDIT CARD OR DEBIT CARD.
   PLEASE DO THIS DURING NORMAL WORKING HOURS –
   MONDAY-THURSDAY 8:00AM-5:00PM AND FRIDAY 8:00AM-3:00PM CST
   THE BOARD OFFICE IS CLOSED JANUARY 1, 2019.

# VERIFICATION OF PRACTICE

NORTH DAKOTA BOARD OF NURSING

SFN 52754 (12-18)

**I. LICENSEE/REGISTRANT INFORMATION**

| Name (Last, First, Middle) | | | Maiden Name (If Married) | *Social Security Number |
|---|---|---|---|---|
| Current Mailing Address | City | State | Zip Code | Date of Birth |
| Telephone Number | | RN/LPN License/UAP Registry Number | | Expiration Date **12/31/2018** |

**II. FACILITY/AGENCY INFORMATION**

| Name of Facility/Agency | | Federal Facility/Agency ____Yes _____No | |
|---|---|---|---|
| Facility Address | City | State | Zip Code |
| Telephone Number | Fax Number | | |
| Name of Verifying Facility/Agency Representative (print) | Title/Position | Date | |

**III. NURSING PRACTICE VERIFICATION: To be completed by your nursing employer.**

**Note: Include volunteer work as an APRN, RN, LPN, UAP, or MA.**

| **Since the expiration date noted in Section I, the above referenced Individual practiced: (Check all that apply)** | **Initial date of practice after expiration of license/registration/ permit** | **Last date of practice** **(NOTE: *this may not be the last date of employment. Do not include a leave of absence or vacation)*** | **State in which practice occurred** |
|---|---|---|---|
| ☐ No Practice has occurred | N/A | N/A | N/A |
| ☐ Practiced as an Advanced Practice Registered Nurse | | | |
| ☐ Practiced as a Registered Nurse | | | |
| ☐ Practiced as a Licensed Practical Nurse | | | |
| ☐ Practiced as an Unlicensed Assistive Person | | | |
| ☐ Practiced as a Medication Assistant | | | |

**I certify the information documented is true, complete, and correct.**

| Signature of Facility/Agency Representative | Date |
|---|---|
| | |

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Return completed form to:
North Dakota Board of Nursing
919 S 7th St., Suite 504
Bismarck ND 58504-5881
Telephone (701) 328-9777
Fax (701) 328-9785
Website www.ndbon.org