NORTH DAKOTA BOARD OF NURSING
INSTRUCTIONS FOR ADVANCED PRACTICE
with or without PRESCRIPTIVE AUTHORITY
LATE LICENSE RENEWAL (SFN 50924)

INSTRUCTIONS/REQUIREMENTS - Please renew online at www.ndbon.org from October 1 through December 31
Renewals completed after December 31 must pay double the renewal fee (listed below) and complete a Verification of Practice form. Applicants must:

1. **Possess or submit one of the following (Your renewal will be delayed if one of the following is not submitted with this application):**
   - **a.** Renew your ND RN license by paying the appropriate fee below
     OR
   - **b.** Have a current compact RN license in ND or another compact state.
     (**see compact information and primary state of residence information below).

   For an up to date list of compact states please go to www.ncsbn.org.
   Primary State of Residence - 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.

2. **Scope of Practice**
   You must verify that your Scope of Practice is consistent with your education and certification by checking the appropriate box on the renewal form.
   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

3. **Continuing Education Contact Hours**
   Each person licensed as a Licensed Practical Nurse, a Registered Nurse, or an Advanced Practice Registered Nurse in ND must complete at least 12 contact hours of approved CE in the past two years to renew their license.

   Those also renewing prescriptive authority must verify completion of fifteen contact hours of education during the previous two years in pharmacotherapy related to the scope of practice. The education may be obtained from one or more of the following methods:
   a. One academic semester hour credit in pharmacotherapy related to scope of practice is the equivalent of fifteen contact hours;
   b. These contact hours may fulfill the registered nurse renewal continuing education requirement. 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.

4. **Practice Requirements**
   Nursing practice for purposes of renewal must meet or exceed four hundred hours within the preceding four years. Nursing is defined in subsection 6 of North Dakota Century Code section 43-12.1-02. Hours practiced in another regulated profession cannot be used for nursing practice hours.

5. **Complete all portions of this application.**
   Complete section 1 on the Verification of Practice Form and have your employer complete the remainder of the form.
   Fax both completed forms to the ND Board of Nursing office at 701-328-9785
   After you have faxed the forms call the Board office immediately to make payment via credit/debit card at 701-328-9788

Nurses renewing APRN & RN license in ND
Renewal of RN & Advanced Practice only……$320

Nurses renewing APRN w RX authority & RN license in ND
Renewal of RN, Advanced Practice, and Prescriptive Authority……$420

Nurses with a current RN in ND or another compact state and renewing APRN only
Renewal Advanced Practice only……..…$80

Nurses with a current RN license in ND or another compact state and renewing APRN & RX Authority
Renewal of Advanced Practice and Prescriptive Authority……$180

****ADD AN ADDITIONAL FEE OF $200 IF PRACTICE OCCURRED AFTER DECEMBER 31, 2018**

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".

2019-2020 TWO YEAR LICENSE LATE RENEWAL APPLICATION APRN with or without PRESCRIPTIVE AUTHORITY

NORTH DAKOTA BOARD OF NURSING
SFN 50924 (01-19)

FOR OFFICE USE ONLY	
Fee received	
CE Requirements	Disc Review
Approval	Date Issued

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

Name (Last, First, Middle, Maiden)		Mothers Maiden 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.

COMPLETE THE MOST APPLICABLE EMPLOYMENT CHOICE FROM EACH CATEGORY

EMPLOYMENT SETTING FOR PRINCIPAL NURSING POSITION

- ☐ Ambulatory Care Clinic
- ☐ Church
- ☐ Government
- ☐ Home Health
- ☐ Hospital
- ☐ Military
- ☐ Nursing Education Program
- ☐ Nursing Home/ Extended Care
- ☐ Occupational Health
- ☐ Physician Office
- ☐ Public/Community Health
- ☐ School Health Services
- ☐ Self Employed
- ☐ Social/Human Services
- ☐ Temporary Agency
- ☐ Other (Please specify)_____

_____

MAJOR CLINICAL PRACTICE OR TEACHING AREA

- ☐ Anesthesia
- ☐ Chemical Dependency
- ☐ Critical Care
- ☐ Emergency Care
- ☐ Family Practice
- ☐ Geriatrics
- ☐ Home Health
- ☐ Maternal/Child Health
- ☐ Medical/Surgical
- ☐ Mental Health
- ☐ Neonatology
- ☐ Nursing Administration
- ☐ Oncology
- ☐ Parish
- ☐ Pediatrics
- ☐ Perioperative
- ☐ Public/Community Health
- ☐ Quality Assurance
- ☐ Rehabilitation
- ☐ School
- ☐ Other (Please specify)_____

TYPE OF PRINCIPAL NURSING POSITION

- ☐ Advanced Practice Registered Nurse
- ☐ Nurse Administrator
- ☐ Nurse Consultant
- ☐ Nurse Educator
- ☐ Nursing Faculty in College of Nursing
- ☐ Nursing Manager
- ☐ Office Nurse
- ☐ Specialty Practice Registered Nurse
- ☐ Staff Nurse
- ☐ Travel Nurse
- ☐ Other (Please specify)_____

COMPLETE THE FOLLOWING. LIST ALL NURSING EMPLOYMENT IN THE PAST 2 YEARS

Practice Year	**PLACE OF NURSING PRACTICE (NAME OF AGENCY, CITY, STATE)**	**HOURS PRACTICED IN NURSING EACH YEAR**
2018		
2017		

LIST ALL OTHER STATES OF ADVANCED PRACTICE NURSING LICENSURE

(Example-MN,SD,MT,NE) use additional paper if necessary

ACTIVE LICENSES	
INACTIVE LICENSES	

HIGHEST EDUCATION COMPLETED

☐ **Vocational Certificate (LPN/VN)**	☐ **Diploma (RN)**	☐ **Masters Degree (Nursing)**	☐ **Doctorate Degree (Nursing)**
☐ **Associate Degree (LPN)**	☐ **Bachelors Degree (Nursing)**	☐ **Masters Degree (Other)**	☐ **Doctorate Degree (Other)**
☐ **Associate Degree (RN)**	☐ **Bachelors Degree (Other)**	☐ **Advanced Practice Post Basic Education**	

NURSE LICENSURE COMPACT INFORMATION – DECLARATION OF PRIMARY STATE OF RESIDENCE

Primary state of residence is the state referred to as your "home state" under the Nurse Licensure Compact (NLC) and means that it is your "declared fixed permanent and principal home for legal purposes".

One or more of the following documents may be used to verify your primary state of residence pursuant to the Compact laws and rules.

1. **Military Form No. 2058 - state of legal residence certificate**
2. **Current driver's license with a home street address.**
3. **Voter registration displaying the primary state of residence.**
4. **Federal income tax return declaring the primary state of residence.**
5. **W2 from US government or any bureau, division or agency thereof indicating the declared state of residence.**

I declare my primary state of residence to be			
My primary state of residence listed above is ND or a state that does not belong to the NLC; OR I am practicing exclusively in a military capacity or a federal institution and do not have a current RN license in any other state	☐ Yes	☐ No	
If you answered "Yes" to this question, complete the following information about your RN license in ND: RN License Number in ND:			
RN license in ND will expire/has expired:			
If my ND RN license is expired, I will reactivate it on this application by including the appropriate fee listed in the instructions	☐ Yes		
My primary state of residence listed above is a state other than ND that belongs to the NLC.			
If you answered "Yes" to this question, complete the following information about your RN license from your primary state of residence: RN License Number in my compact primary state of residence is:	☐ Yes	☐ No	
RN license in my compact primary state of residence will expire:			

ARMED SERVICES OR FEDERAL EMPLOYEE INFORMATION

***A federal government/military nurse practicing exclusively in federal or military systems, need only have one license from any state or territory per U.S. federal government/military policy. A federal or military nurse who also practices in a civilian health system is bound by the Compact law and rules.**

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

CONTINUING EDUCATION

☐ 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.

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.	☐ YES	☐ NO
2.	Are there any pending charges against you with respect to a felony or misdemeanor offense?	☐ YES	☐ NO
3.	Have you had an unlicensed assistive person registry or nurse aide registry listing marked for abuse, neglect or misappropriation of property?	☐ YES	☐ NO
4.	Has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	☐ YES	☐ NO
5.	Have you been investigated or are you presently being investigated by any other jurisdiction?	☐ YES	☐ NO
6.	Have you been denied registration or nursing licensure by any other jurisdiction?	☐ YES	☐ NO
7.	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 question above, attach a detailed written explanation and related legal documents to the application and send to the board.			

SCOPE OF PRACTICE

☐ 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 as listed in the instructions. ☐ YES ☐ NO

CONTINUING EDUCATION FOR PRESCRIPTIVE AUTHORITY – ANSWER IF ALSO RENEWING PRESCRIPTIVE AUTHRITY

☐ 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.

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

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

VERIFICATION OF PRACTICE

NORTH DAKOTA BOARD OF NURSING

SFN 52754 (01-19)

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

*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.

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