



Registered Nurse Renewal Application

Current Expiration 3/31/2011	Renewal Period Covering 4/1/2011 – 3/31/2013	Renewal Application Fee \$95.00 Non-Refundable Processing Fee
You Must Complete The Information Below:		For Office Use Only
License Number: _____		
Name: _____		
Address: _____		
City/State/Zip: _____		
Circle One:	Mr. Mrs. Ms.	

Directions: To renew you must enclose a check in the amount indicated, payable in US funds from a bank with a United States affiliate to "Office of the Secretary of State." The renewal application fee is non-refundable. If the completed renewal, along with all supporting documentation, is not received by the expiration date you will be required to pay a late renewal penalty. The penalty is \$25.00 for renewals submitted less than 30 days late. Thereafter, the penalty increases by \$5.00 for every additional month or fraction of a month, not to exceed \$100.00.

****Reminder: You may not practice your licensed profession without an Active license.**

Has your name changed since you last renewed, or if this is your first renewal since you were originally licensed?	(Circle One)	
	Yes	No
<i>If "Yes," you must attach a copy of your marriage license, civil union license or section of divorce decree granting you the authority to change your name.</i>		

Section A: Demographic Information

If your mailing address has changed, indicate your new address in the box to the right. Note: It is unprofessional conduct for a licensee to fail to notify the Secretary of State's Office of a change of name or address within thirty (30) days (3 V.S.A. § 129a(a)(14).	P.O. Box
	Street/Apt #
	City/State/Zip
	Country

If your 911 address has changed, indicate your new address in the box to the right.	P.O. Box
	Street/Apt #
	City/State/Zip

Phone: () -	Cell Phone: () -
Fax: () -	E-Mail Address:

Date of Birth	Place of Birth (City, State, Country)	Gender (Circle One)	
		Female	Male

Social Security Number: _____ / _____ / _____ ****** (Providing your social security number (SSN) is mandatory, and requested under the authority granted by 42 U.S.C. §405(c)(2)(C). It will be used by the Departments of Taxes, Child Support, and the Department of Labor in the administration of Vermont law, to identify individuals affected by such laws. Your SSN is not disclosed as part of a public records request);

OR

Passport Number: _____ ******* (If you do not have a social security number you must provide a passport number as evidence that there is no attempt to procure a license fraudulently (3 V.S.A. §129a)

Section B: Vermont Mandatory "Good Standing" Declarations

CHILD SUPPORT:

Child Support Orders (15 V.S.A. § 795(c)): As of the date of this application: (you must check one)	
<input type="checkbox"/>	I am not subject to a child support order; OR
<input type="checkbox"/>	I am subject to a child support order and am in good standing* or in full compliance with a plan to pay; OR
<input type="checkbox"/>	I am not in good standing* or in full compliance with a plan to pay.*

TAXES:

Tax Compliance (32 V.S.A. § 3113(b)): As of the date of this application: (you must check one)	
<input type="checkbox"/>	I have never lived or worked in Vermont and do not owe Vermont taxes; OR
<input type="checkbox"/>	No taxes are due and payable and all required returns have been filed; OR
<input type="checkbox"/>	The liability for any taxes due and payable is on appeal; OR
<input type="checkbox"/>	I am in compliance with a payment plan approved by the Vermont Department of Taxes; OR
<input type="checkbox"/>	I am not in good standing* with the Vermont Department of Taxes or in full compliance with a plan to pay.

DISTRICT COURT FINES / JUDICIAL BUREAU:

Unpaid Judgments (4 V.S.A. § 1110(b&c)): As of the date of this application: (you must check one)	
<input type="checkbox"/>	I do not have any unpaid judgments
<input type="checkbox"/>	I am in good standing* with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense; OR
<input type="checkbox"/>	I am not in good standing.*

* "Good standing" is defined in the statutes cited above. For more information, refer to the relevant statute specific to the particular question.

Section C: Vermont Mandatory Credential and Fitness Questions

Please circle **Yes** or **No** for each of these questions. If the answer is **Yes** follow the provided instructions.

Since you were originally licensed (and this is your first renewal), or since you completed your last renewal application:

Have you committed acts of abuse, neglect, or misappropriation of patient property? <i>If "Yes," provide a detailed written explanation and attach all related documents.</i>	Yes	No
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Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) denied your application for a license, certificate, or registration in any profession or occupation? <i>If "Yes," attach a copy of the order or official notification of the action.</i>	Yes	No
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Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) restricted, suspended, revoked, or taken any other disciplinary action against a license, certificate, or registration that you hold or held in any profession or occupation? <i>If "Yes," provide a copy of the order or official notification of the action.</i>	Yes	No
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Have you surrendered a license, certificate, or registration to a licensing authority? <i>If "Yes," provide a detailed written explanation.</i>	Yes	No
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Are you currently under investigation by another licensing authority? <i>If "Yes," provide a detailed written explanation and a copy of any available information from the licensing authority.</i>	Yes	No
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Have you been convicted of a crime other than a minor traffic violation? (Driving While Intoxicated and Driving Under the Influence are not minor) <i>If "Yes," provide a detailed written explanation and attach the official certified court documents.</i>	Yes	No
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Do you have any criminal charges pending against you in any jurisdiction (US or elsewhere)? <i>If "Yes," provide a detailed written explanation and attach a copy of the charging documents.</i>	Yes	No
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Note: Vermont law requires that you report to the Office of Professional Regulation, a felony conviction or any conviction of a crime related to the practice of your profession; within 30 days. 3 V.S.A. § 129a(a)(11).

Do you have a physical or mental condition or disorder which in any way impairs or limits your ability to practice this profession with reasonable skill and safety? <i>If "Yes," please have your provider submit a detailed statement explaining how you are able to practice safely.</i>	Yes	No
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Does your use of alcohol, drugs, or medications in any way impair or limit your ability to practice this profession with reasonable skill and safety? <i>If "Yes," provide a detailed written explanation.</i>	Yes	No
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Are you currently addicted to or in any way dependent on, the use of alcohol or habit forming drugs? <i>If "Yes", provide a detailed written explanation.</i>	Yes	No
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Are you currently participating in a supervised program or professional assistance program which monitors you in order to assure that you are not engaging in the use of alcohol or controlled substances? <i>If "Yes," please provide the contract/stipulation under which you are practicing.</i>	Yes	No
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Section D: RN Nursing Education Program Requirements

Provide the name and location of your original/initial RN NURSING PROGRAM		Name	
City	State	Country	

Provide the name of the US STATE from which you received your ORIGINAL RN LICENSE.	Name of State
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Have you graduated from your original/initial RN Nursing education program within the last five (5) years (04/01/2006 – 03/31/2011)?	Yes	No
Provide the date of completion of this nursing program (MM/DD/YYYY).	/	/

If you answered “Yes” in section D (you have completed a nursing education program within the last 5 years) – you may skip sections E, F and G. No further information is required with the exception of Section H, your signature and date.

If you answered “No” in section D (you have NOT completed a nursing education program within the last 5 years) – you must answer Section E and ALL of Section F (including Employment History).

If you practiced in a private duty or volunteer capacity you must also answer Section G. Then provide your signature and date in Section H.

Section E: RN RE-ENTRY Program Requirements

Have you successfully completed a Board approved RN Re-entry program within the last five (5) years (04/01/2006 – 03/31/2011)?	Yes	No
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Provide the name and location of your RN RE-ENTRY PROGRAM		Name	
City	State	Country	

Provide the date of completion of this re-entry program (MM/DD/YYYY).	/ /
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If you answered “Yes” in section E (you have completed a re-entry program within the last 5 years) – you may skip sections F and G. No further information is required with the exception of Section H, your signature and date.

Section F: Practice & Experience Requirements

Chapter 5. NURSING Subchapter 2 LICENSURE AND ENDORSEMENT IV. LICENSE RENEWAL

Practice of nursing at the level of licensure within the past five years means practice as described in 26 V.S.A. § 1572, definitions, for at least 120 days, 960 hours, in the five years prior to the expiration date or 50 days, 400 hours, within the two years prior to the expiration date. Eight hours are equivalent to one day of nursing practice.

<p><u>Have you practiced as an RN:</u></p> <p>for 50 days (400 hours) within the last two (2) years</p> <p>-OR-</p> <p>for 120 days (960 hours) within the last five (5) years?</p>	Yes	No
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Provide the following information for all RN employment within the last five (5) years

(Most recent employment first):

****DO NOT complete this section if your original/initial RN program was completed within the last 5 years****

Your Job Title		
Paid or Volunteer?		
Full time	Yes	No
Part time	Yes	No
Date of Employment	<u>From (MM/DD/YYYY)</u> / /	<u>To (MM/DD/YYYY)</u> / /
Name of Agency/Institution		
Mailing Address	P.O. Box	
	Street/Apt #	
	City/State/Zip/Country	
Agency/Institution Phone #		
Supervisor's Name and Title		
Supervisor's Phone Number		

Your Job Title		
Paid or Volunteer?		
Full time	Yes	No
Part time	Yes	No
Date of Employment	<u>From (MM/DD/YYYY)</u> / /	<u>To (MM/DD/YYYY)</u> / /
Name of Agency/Institution		
Mailing Address	P.O. Box	
	Street/Apt #	
	City/State/Zip/Country	
Agency/Institution Phone #		
Supervisor's Name and Title		

Supervisor's Phone Number	
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Your Job Title		
Paid or Volunteer?		
Full time	Yes	No
Part time	Yes	No
Date of Employment	<u>From (MM/DD/YYYY)</u>	<u>To (MM/DD/YYYY)</u>
	/ /	/ /
Name of Agency/Institution		
Mailing Address	P.O. Box	
	Street/Apt #	
	City/State/Zip/Country	
Agency/Institution Phone #		
Supervisor's Name and Title		
Supervisor's Phone Number		

Your Job Title		
Paid or Volunteer?		
Full time	Yes	No
Part time	Yes	No
Date of Employment	<u>From (MM/DD/YYYY)</u>	<u>To (MM/DD/YYYY)</u>
	/ /	/ /
Name of Agency/Institution		
Mailing Address	P.O. Box	
	Street/Apt #	
	City/State/Zip/Country	
Agency/Institution Phone #		
Supervisor's Name and Title		

Supervisor's Phone Number	
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Section G: Private Duty or Volunteer

Did you practice as a Registered Nurse in a private duty or volunteer capacity?	Yes	No
<p>If YES to the question above attach the following documentation:</p> <p>Private Duty:</p> <ol style="list-style-type: none">1. An Official letter from the client/patient's Attending Physician or Advanced Practice Registered Nurse (APRN) on their letterhead, stating that RN care was required. The letter must clearly list the Physician's or APRN name, title, contact telephone number and have their signature.2. A letter from your Employer or Client, verifying your role and duties as a Private Duty Nurse. They must verify the number of days, hours and dates worked. The letter must clearly list the Employer/Clients name, contact telephone number, email address, mailing address and have their signature. <p>Volunteer:</p> <ol style="list-style-type: none">1. An Official letter from your Employer sent directly to the Vermont Board of Nursing office from the Director of Nursing or Director of Human Resources. A copy of your Job Description as a Volunteer Nurse, and a letter listing the number of days, hours and dates worked. The letter must clearly list the name of the Director of Nursing or Director of Human Resources, their telephone number, email address, mailing address and have their signature		

Section H: Affirmation

Statement of Applicant

I certify, under the pains and penalties of perjury, that all information I have provided in this application is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application for renewal or further disciplinary action. The maximum penalty for perjury is fifteen years in prison and/or a \$10,000 fine. (13 V.S.A. §2901)	
Signature of Applicant	Date

Renewal Form Registered Nurse (RN) March 2011

Office of Professional Regulation Survey (optional)

Would you be willing to serve as an Ad Hoc member of the Board/Commission/Advisory panel for your profession? <i>If you answer "Yes," submit a letter of intent and resume to the Office for consideration.</i>	Yes	No
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Would you be willing to serve as a Board/Advisor member of the Board/Commission/Advisory panel for your profession? <i>If you answer "Yes," submit a letter of intent and resume to the Office for consideration.</i>	Yes	No
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Would you be willing to serve as an Expert Witness for licensing cases associated with your profession?	Yes	No
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If you answered "Yes" to the question above, what is your area of expertise?