Alabama Board of Nursing
Peggy Sellers Benson, RN, MSHA, MSN, NE-BC
Executive Officer

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Mailing address:
P.O. Box 303900
Montgomery, AL 36130-3900

APPLICATION FOR REINSTATEMENT OF A REVOKED NURSING LICENSE

Part A – IDENTIFYING INFORMATION *(Mandatory Completion Required)*

O N/A **RN license #: 1 - __ __ __ __ __ __**

O N/A **LPN license #: 2 - __ __ __ __ __ __** **DOB: _____ / _____ / _____**
Month Day Year

NAME*: _____

Previous Names / Aliases used*: _____

YES	NO	ATTORNEY REPRESENTATION
		I am represented by an Attorney. **Attorney contact info:**
		Letter of Representation from Attorney included with application.

YES	NO	STANDARD
		Application submitted at least twelve months after the effective date of revocation.
		Application fee included (*non-refundable*) As of December 23, 2013, the application fee is $750. Please see Alabama Board of Nursing Administrative Code § 610-X-4-.14 for further information on acceptable payment methods.
		Acceptable payment method type: _____
		Citizenship/Legal presence checklist included (See website; form is separate from this application).
		If you are now using a different name* than the one you were most recently licensed under, please submit appropriate documents with your application. Please see Alabama Board of Nursing Administrative Code § 610-X-4-.11 for further information on notice requirements.

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Instructions: Type or print in ink all information in the area provided. Additional sheets may be attached if necessary. If additional sheets are attached, you must clearly identify the section/question to which the attachment pertains. Many sections/questions on this application require the submission of additional supporting documentation. It is the applicant's responsibility to ensure that this information is submitted to the Board with the application, or that the information is received in a timely manner to coincide with application submission. Incomplete applications may not be considered by the Board.

	EXAMPLE
1	*Nursing licensure verification from Nursys® will be submitted directly to the Board. The applicant should include proof that this has been requested, such as the receipt of payment for the verification and expected states that will be submitting verifications to the Board.*
2	*Treatment provider records pertinent to the Reinstatement Application are often submitted directly to the Board by the provider. The applicant should ensure these records have been received prior to submitting the application.*
3	*Affirmative responses to regulatory questions require supporting documentation pertinent to the response.*

PART B – DEMOGRAPHICS

1. Address (***Mandatory***):

   _____

   _____

   _____

2. Telephone:

   (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ O Cell O Home O Other _____

   (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ O Cell O Home O Other _____

3. Email address (***Mandatory***):

   _____ @ _____

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PART C – REGULATORY QUESTIONS

(Yes answers below require supporting documentation. Please refer to Instructions Example 3)

YES	NO	STANDARD
		Criminal History (See also Part J)
		1. Regarding a crime (felony or misdemeanor) in any state, territory, or country: Have you ever:
		Been convicted?
		Pleaded guilty?
		Entered a plea of nolo contendere or no contest?
		Received deferred prosecution?
		Received pretrial diversion?
		Received deferred adjudication?
		Had judgment withheld?
		Pleaded not guilty by reason of insanity or mental defect?
		Other (please provide a *detailed* explanation):
		2. Since the revocation/voluntary surrender of your license:
		Have you been arrested for and/or charged with *any* crime other than a *minor* traffic violation? (Minor traffic violations = speeding ticket, red light ticket, window tinting, etc.)
		Do you have any pending criminal charges?
		3. Regarding *any* allegations of driving while under the influence or while impaired by alcohol or any other substance:
		Have you *ever* been arrested, charged, or ticketed?
		*If the above is yes, have you previously disclosed this information to the Board and provided complete records to the Board?
		Have you *ever* had any alcohol or other substance-related arrest? (i.e., Public Intoxication)
		*If the above is yes, have you previously disclosed this information to the Board and provided complete records to the Board?
		Professional License History
		4. Regarding the licensing authority of any state (other than Alabama), territory, or country, have you ever:
		Had any disciplinary action?
		Do you have any pending matters, such as a current investigation?
		5. Have you ever had something other than a "license" issued to you, such as:
		Registration, certification, or approval?
		Other (please provide a detailed explanation)?
		Employment History
		6. Regarding your employment or ability to practice, has any health care facility, office, or practice:
		Terminated your employment?
		Accepted your resignation in lieu of termination?
		Withdrawn approval for or cancelled your training?
		Withdrawn your privilege to practice?
		Other (please provide a detailed explanation)?

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YES	NO	Military History
		7. Has any branch of the armed services administratively discharged you with any characterization of service besides "Honorable" and/or court-martialed you?
		Fitness for Duty History
		8. Regarding your ability to provide safe nursing care, have you ever:
		Suffered from or been diagnosed with, a *physical* problem that may impair your ability to provide safe nursing care?
		Suffered from or been diagnosed with, a *mental or psychiatric* problem that may impair your ability to provide safe nursing care?
		Abused alcohol, drugs (whether legal or illegal, prescribed or unauthorized), and/or other chemical substances?
		Received treatment for abuse or dependency to alcohol, drugs (whether legal or illegal, prescribed or unauthorized), and/or other chemical substances?
		Been recommended for treatment for abuse or dependency to alcohol, drugs (whether legal or illegal, prescribed or unauthorized), and/or other chemical substances?
		Been ordered by a court to participate in a treatment program or a program of random drug screening?
		Been recommended for or received counseling for substance use?

PART D – CONTINUING EDUCATION (CE)

YES	NO	STANDARD
		24 hours of CE earned within the 24 months preceding application submission Please see Alabama Board of Nursing Administrative Code §§ 610-X-4-.10 and 610-X-10 for further information on CE.
		CE certificates included (please submit in chronological order)
		Have you used any other methods besides CE to maintain/improve your knowledge and skill regarding the practice of nursing since the loss of your license? *(e.g., volunteer work, non-licensed healthcare employment, etc.)* If yes, please briefly explain below:
		Was a contributing factor to the loss of your license due to your failure to complete CE ordered by the Board?
		If the above is "YES," did you complete the previously ordered CE (or equivalent course) as a component of this application?
		At least one CE course completed relevant to the specific conduct that resulted in the loss of your license. *(e.g., Substance Use, Pain Management, etc.)*

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PART E – DETAILED LETTER OF EXPLANATION

YES	NO	N/A	STANDARD
			I have attached a **detailed letter of explanation** regarding the circumstances that resulted in the revocation of the license and actions I have taken to address the issue.
			My license was revoked for failure to comply with any previously stipulated terms of a Board Order such as completion of a course or payment of a fine:
			I have saved the money and am prepared to pay the outstanding fine upon reinstatement.

PART F – LICENSURE IN OTHER JURISDICTIONS/PROFESSIONS

YES	NO	VERIFICATION OF LICENSURE IN ANOTHER JURISDICTION
		Are you *currently* licensed, certified, or registered as a nurse or other health-related professional in any state, territory, country, or other type jurisdiction?
		Have you *ever* been licensed, certified, or registered as a nurse or other health-related professional in any state (besides Alabama), territory, country, or other type jurisdiction?
		Are you currently or have you ever been, licensed, certified, or registered in a *non*-health related profession by any jurisdiction?
		If "NO" to all of the above, proceed to Part G. **If "YES" to any of the above, continue below.**
		Nursys verification requested for the following jurisdictions:
		Proof of *Nursys (Please refer to Instructions Example 1)* request submitted with application (*Example: receipt of payment*)
		Verification(s) requested for all health-care related licenses, certifications, and registrations from every jurisdiction/entity which issued it *(e.g., Nursing license from a jurisdiction which does not offer verification via Nursys; Pharmacy Tech certificate, or Assisted Living Administrator license issued by Alabama or another state)*. List expected submissions and provide proof of request:
		Correct process followed of the jurisdiction/entity from which you are requesting verification to be sent the ABN
		Disciplinary orders issued by another jurisdiction/entity expected to be included with licensure verification? If so, identify where:

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PART G – EMPLOYMENT HISTORY

List ALL employment chronologically since graduation from your nursing school to the present. Explain periods of unemployment. Attach additional sheets if necessary.

Date		**Employer** Name, City & State *Example: VA Hospital, Birmingham, AL*	**Position/ Title/ Duties**	**Reason For Employment Leaving** *Example: Termination, Resignation, Loss of license, etc.*	**Supervisor / Contact Info** (if known)
From Month/Year	To Month/Year				

PART H – AFFIDAVITS

List the names and telephone numbers of the individuals whom are submitting affidavits *(See Form 1)* on your behalf which are included with this application. Affidavits must be submitted to you in a sealed envelope signed across the seal by the affiant.

Name of Affiant	Relationship / How known	Telephone Number
1.		
2.		
3.		
4.		
5.		

PART I – TREATMENT

YES	NO	N/A	STANDARD
			I have received treatment for, or been recommended for, treatment for a Substance Use Disorder. *(i.e., "Rehab")* See Section I.1 & I.3
			I have received treatment for, or been recommended for, treatment for a Mental or Psychiatric Disorder. See Section I.2 & I.3
			If "NO" to both of the above, proceed to Part K. **If "YES" to either of the above, continue below.**
			Section I.1 **SUBSTANCE USE DISORDER**
			A **Comprehensive Evaluation (Substance Use Disorder)** from a *Board-recognized treatment provider* whose program includes a health care professionals tract completed no more than ***12 months*** prior to the date of the application **is required if:** (1) the circumstances that resulted in the revocation of the license involved *allegations* of substance abuse, substance dependence, or drug diversion, OR (2) the license was revoked while encumbered by an order requiring a program of random drug screening, OR (3) conduct following the loss of the license resulted in alcohol or drug-related arrests, and/or your participation in a CRO/"color code" program was required by the court. Date of Evaluation: _____
			Signed Release of Information (See **Form 3**) authorizing the sharing of information from Board staff to identified healthcare providers (Board staff consultation). The treatment provider will also require you to sign releases in order to submit your information to the Board *(please refer to Instructions Example 2).*
			Board-recognized treatment provider: (Circle one) UAB-ARP Bradford-Warrior Pine Grove COPAC Talbott
			Evidence of compliance with all treatment provider recommendations:
			Abstinence-Oriented Support Group *("12 step, AA, NA," etc.)* meeting attendance (minimum of 3 meetings per week)
			Sponsor statement *(e.g., Letter or Affidavit)*
			Individual Therapy *(e.g., Letter or Affidavit)*
			Other: _____
			Other: _____
			Drug Screens: Complete results of no less than **12 months** of participation in the Board-recognized program of random drug testing immediately prior to the date of application. *The detailed results must be submitted, not just the "Results Certificate" or multi-test results obtained via your online account*.
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YES	NO	N/A	Section I.1 (Continued) SUBSTANCE USE DISORDER
			Evaluator statement regarding fitness to return to the practice of nursing. (This is given upon the conclusion of the Comprehensive Evaluation and compliance with any necessary recommendations).

List any activities which you have completed or are currently attending to address the issue(s) surrounding the revocation of your license. **Submit supporting documentation for each activity listed** (*Form 2 may be utilized for this purpose*).
*You should ensure that activities align with recommendations provided by a treatment provider.
*You may include any Community Services or Recreational activities in which you engage here.

Date		**Activity:**	**Name & Location of Activity:**	**Frequency:**
From Month/Year	To Month/Year	Abstinence-oriented support group meetings, i.e., 12 step meetings; Individual Therapy; Drug Screening; etc.	*Example:* *Lunchtime Reflections, Mobile, AL* *Sue Jones, Therapist, Daphne, AL*	*Example:* *Daily, Monthly, etc.*

YES	NO	N/A	Section I.2 MENTAL/PSYCHIATRIC DISORDER
			If the circumstances that resulted in the revocation of the license involved *allegations* of **physical or mental impairment** the applicant shall provide:
			(1) Current **neuropsychological evaluation** (Contact Legal Division Nurse Consultant for Reinstatement of Revoked License for referral.)
			(2) Current **physiological evaluation** (Primary Physician/ Psychiatrist)
			(3) Documentation of compliance with all treatment/evaluating provider recommendations. List recommendations below: (a) _____ (b) _____ Other:
			(4) **Evaluator statement regarding fitness to return to the practice of nursing.** (This is given upon the conclusion of the necessary evaluation(s) and compliance with any necessary recommendations. This often requires communication between your selected providers and Board staff.)

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YES	NO	N/A	Section I.2 (Continued) MENTAL/PSYCHIATRIC DISORDER
			Signed Release of Information (See **Form 3**) authorizing the sharing of information <u>from</u> Board staff <u>to</u> the identified healthcare provider(s) (Board staff consultation). The provider will also require you to sign releases in order to submit your information to the Board *(please refer to Instructions Example 2).*

Section I.3
COMPLETE TREATMENT HISTORY

Complete the area below for **<u>each</u>** treatment you have ever received, even if you did not complete the program. Attach additional sheets if necessary.

Date		Type of Treatment: Residential, PHP, IOP, Inpatient Psychiatric, etc.	Name, City, & State of Program/Facility *Example: Bradford Extended Care Program, Warrior, AL*	Jurisdiction if Court-ordered *Example: Madison County, AL*
From Month/Year	To Month/Year			

PART J – CRIMINAL HISTORY (See Form 4)

YES	NO	N/A	STANDARD
			Arrests/Convictions
			Previous charges?
			Were these charges previously disclosed to the Board with all supporting documentation submitted? If NO, complete Form 4.
			Pending charges? If YES, complete Form 4.
			Felony
			Misdemeanor

You should be prepared to explain any arrests or charges that had an impact upon the revocation of your license, regardless of the disposition of the charges. Further, you should be aware that satisfying the requirements of the Court (e.g., treatment, drug screens, etc.) typically do NOT also satisfy the requirements necessary to complete an application for reinstatement of a revoked nursing license.

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PART K – CERTIFICATION

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying documents are true, complete, and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial of reinstatement.

_____ _____, 20_____

Applicant Signature Month Day Year

Submit Application and all supporting documentation to:

Alabama Board of Nursing
P.O. Box 303900
Montgomery, AL 36130-3900

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