Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810
Main Telephone: (225) 755-7500
www.lsbn.state.la.us

Dear Applicant:

This packet contains the ***2014 Application for Reinstatement by Advanced Practice Registered Nurse and required forms***. Completed applications and forms must be **mailed** to the Board of Nursing for processing; **faxed copies are not acceptable**. If you have not worked in nursing for 5 years or more, please contact our *Reinstatement Department* for further information before submitting an application for reinstatement. All fees are non-refundable. **An APRN license cannot be reinstated until the Louisiana RN licensure status is active.**

If your Louisiana Advanced Practice Registered Nurse license has been Inactive, Delinquent or Retired for *five (5) years or more*, you are **required** to submit to a Criminal Background Check (CBC) as part of the reinstatement process. Please refer to the Fingerprint Instructions and Authorization Forms for Criminal Background Check (CBC) at the end of this reinstatement packet which explains the CBC process, additional CBC fee and authorization forms that must be submitted along with your application for reinstatement.

Please submit all required documents and fees together in one (1) complete packet to avoid delays in the processing of your reinstatement request. Incomplete or partial application packets can not be processed.

Please indicate the documents being submitted to meet the requirements for reinstatement/relicense:

☐ Application for Reinstatement by Registered Nurse. (Use BLUE ink to sign application)

☐ Application for Reinstatement by Advanced Practice Registered Nurse. (Use BLUE ink to sign application)

☐ $200.00 Reinstatement fee ($100.00 for each application – RN & APRN). **Money Order** or **Bank Cashier's Checks** *only*. Personal Checks and/or Cash are **not** accepted. Fees are subject to change

☐ APRN Employment Verification Form - Reinstatement. This form must be given to the APRN applicant's current employer to complete/sign. Applicant must return the completed form along with their reinstatement application packet. If not currently working, have this form completed by your last nursing employer.

☐ We must receive evidence of certification/recertification ***directly from*** the national nursing certification organization approved by the Louisiana State Board of Nursing in your APRN role and population focus/specialty. Reinstatement will be delayed until proof of certification has been received by LSBN's Reinstatement Department from your national organization.

NOTE - APRN's applying for reinstatement of an advanced practice role and population focus/specialty where certification is not available, shall submit the following documentation for **each year** of inactive (or lapsed) Louisiana license status:

* minimum of 300 hours of practice as a fully licensed or permitted APRN for each year of inactive or lapsed status, up to a maximum of 800 hours (Utilize VR-1 form available at LSBN website);

And

* a minimum of two (2) academic/college credit hours relevant to the advanced practice role and population focus/specialty for each year. (Official transcript required for this option); ***or***
* a minimum of 30 continuing education contact hours relevant to the advanced practice role and population focus/specialty for each year. Continuing medical education (CME) units/credits may be utilized by the APRN to meet this requirement. (CEs must be at the advanced level and accredited by an organization accepted by LSBN, see VR-1 form at LSBN website for list)

☐ Criminal Background Check packet with additional money order if inactive for 5 years (or more), ***or*** **if otherwise required as directed in the separate RN Reinstatement Application, Section III, question # 1**.

Rules regarding Requirements for Reinstatement/Relicensure may be located the LSBN website: www.lsbn.state.la.us, Chapter 33, in subsection 3335.D-F. Applications expire one year from date submitted.

NOTE: Louisiana nursing licenses are **calendar** year licenses that must be renewed each fall for the next year. All licenses expire January 31st if not successfully renewed online by the nurse prior to this deadline.

LOUISIANA STATE BOARD OF NURSING

17373 Perkins Road, Baton Rouge, LA 70810
Phone: (225) 755-7500
www.lsbn.state.la.us

APPLICATION FOR REINSTATEMENT BY REGISTERED NURSE

		2014
LICENSE NO.		**YEAR**

FOR OFFICE USE ONLY
MONEY ORDER NO. _____ CASHIERS CHECK NO _____
CE _____ VOE _____ APPROVED _____

PRINT ALL INFORMATION BELOW (Legal documentation must be provided for name change)
APPLICANT'S CURRENT MAILING ADDRESS & CONTACT INFORMATION:

Applicant's Current Name: _____
Current Mailing Address: _____
City, State & Zip: _____
Home Phone Number: (_____) _____
Cell Phone Number: (_____) _____
E-mail Address:_____

EMPLOYER ADDRESS: Employer Name: _____
Address: _____
City, State & Zip: _____
Employer Phone Number: (_____) _____

APPLICATION MUST BE *SIGNED* WITH BLUE INK. Rest of application must be either typed - or - completed with Blue or Black ink. Read separate instructions fully. Any errors or omissions will delay reinstatement.

Section I. I Hereby Apply For:

_____ **Active Status from Inactive/Retired/Delinquent Status** **$100.00 fee**

APPROPRIATE FEES MUST BE SUBMITTED ALONG WITH THIS APPLICATION -

- Please read the ***full*** Instructions for Applying for RN Licensure by Reinstatement *before* completing and submitting this application to ensure you are eligible to apply.
- **Money Order** or **Bank Cashier's Checks *only***. Personal Checks or Cash are **not** accepted.
- Fees are NOT refundable

Applications not completed within one (1) year from date of submission will be closed and cancelled

Section II. Requirements for Reinstatement/Relicensure

I have met the requirements for reinstatement/relicensure by: (select *only* **one (1)** of the following options below and submit documentation demonstrating compliance along with this application and reinstatement fee)

NOTE: Nursing Continuing Education (CE) certificates of completion to document contact hours must show the nursing course completed by the individual was approved/accredited by *either* the American Nurses Credentialing Center (ANCC) ***or*** a U.S. State Board of Nursing.

_____ Minimum of five (5) ANCC or State BON accredited contact hours of nursing continuing education (CE) and written/signed employment verification demonstrating at least 1600 hours of nursing practice last year (full-time).

_____ Minimum of ten (10) ANCC or State BON accredited contact hours of nursing continuing education (CE) and written/signed employment verification demonstrating at least 160 hours of nursing practice last year, but under 1600 hours (part-time).

_____ Fifteen (15) ANCC or State BON accredited nursing continuing education contact hours for each year since my Louisiana RN license became inactive/delinquent. I had less than 160 hours of nursing employment last year.

_____ Documentation showing completion of a RN Refresher Course approved by the Louisiana State Board of Nursing as evidence of compliance with requirements for individuals with non-nursing practice for four (4) years or more (Rule 3335.D.2.a). (See LSBN website for list of approved refresher courses).

_____ Initial (1st) RN license for the State of Louisiana was issued during 2013.

_____ Certification in a nursing specialty recognized by the LSBN Board (see LSBN website for full list)

Name of Applicant (provide at top of each page):_____

Section III. Compliance

YOU ARE HEREBY DIRECTED TO DISCLOSE ALL APPLICABLE MATTERS AS FOLLOWS:

1. **Yes__No__ Have you *ever* been issued any of the following:**
   - a citation or summons for, *and/or*
   - has/have warrant(s) been issued against you related to, *and/or*
   - have you been arrested, charged with, arraigned, indicted, convicted of, *and/or*
   - pled guilty/"no contest"/nolo contendere/"best interest" or any similar plea to, *and/or*
   - been sentenced for any criminal offense, including all misdemeanors and felonies, in any state or other jurisdiction?

     NOTE: Even though an arrest or conviction has been pardoned, expunged, dismissed, deferred, ***or*** diverted, and even if your civil rights have been restored, you must answer "**YES**" and mail certified court documents of incident/arrest together with a signed letter of explanation.
   - **DWI arrest must be reported, regardless of final disposition.**
   - **Traffic violations such as speeding or parking tickets do not need to be reported**.

*If the above question was answered '***Yes***', then:*

Yes__No__ Have you previously reported/provided the following information to the Louisiana State Board of Nursing?
If you answered '**No**' here, and/or had *not* reported/provided the following, then submit with application:

- *Provide a narrative explanation (dated and signed) with date of any/all citations, summons, warrants, arrests, charges, arraignments indictments, convictions, pleas, sentence,*
- *the name of parish/county in which arrests, etc., occurred,*
- *the names of arresting agencies,*
- *the violation(s) listed,*
- *the final disposition of any/all criminal matters, and current status, if no final disposition.*
- *Enclose certified true copies of any/all arrest report(s), etc., occurrence/narrative/supplemental reports; certified true copies of any/all court minute entries and court judgments/orders; copies of probation/DA diversion or Pretrial Intervention programs, etc., and any/all other relevant records.*
- ***Immediately submit to a Criminal Background Check (CBC) as part of the reinstatement application process.*** Click on the link to "Fingerprint Instructions and Authorization Sheet for Criminal Background Check" available at the LSBN website. *Please read instructions carefully*. Fingerprinting may be completed at LSBN Board Office located at 17373 Perkins Road, Baton Rouge, Louisiana 70810, Monday through Friday 9:00 AM to 3:00 PM (excluding holidays), ***or*** may be completed at your local law enforcement office as explained in the fingerprinting instructions. Two FBI fingerprint cards, both CBC authorization sheets and additional CBC fee must be submitted along with this application for processing.

Name of Applicant (provide at top of each page): _____

2. Yes__No__ **Have you had a license to practice nursing or as another health care provider denied, revoked, suspended, sanctioned, or otherwise restricted or limited, including voluntary surrender of license - including restrictions associated with participation in confidential alternatives to disciplinary programs?** *and/or*

   Have you had disciplinary action pending by a licensing board—other than by Louisiana State Board of Nursing—in any state or jurisdiction?

   *If either of the above questions were answered '***Yes***', then:*

   Yes__No__ Have you previously reported/provided the following information to the Louisiana State Board of Nursing? If you answered '**No**' here, and/or had *not* reported/provided the following, then submit with application:

   - *Provide a narrative explanation (dated and signed) with date of and description of any/all actions by other licensing boards in Louisiana and in other states or jurisdictions* ***(beside the Louisiana State Board of Nursing)****, including names of other boards at issue, status of any/all disciplinary matters with other boards,*
   - *Enclose certified true copies of any/all other board actions by other licensing boards, along with any/all related and/or subsequent actions.*

3. Yes__No__ **Have you been discharged from the military on ground(s) other than an honorable discharge?**

   *If the above question was answered '***Yes***', then:*

   Yes__No__ Have you previously reported/provided the following information to the Louisiana State Board of Nursing? If you answered '**No**' here, and/or had *not* reported/provided the following, then submit with application:

   - *Provide a narrative explanation (dated and signed) of the other-than-honorable discharge, with date(s) of incident(s) involved, detailed description of grounds for discharge, along with description of the surrounding circumstance and any/all other relevant information.*
   - *Enclose photocopies of any/all military discharge documents, including any/all documentation of the underlying action(s) that resulted in discharge, with any/all other related records.*

4. Yes__No__ **Have you been named as a defendant in a civil/malpractice case relating to your practice of nursing?** *and/or*

   Has a medical review panel opinion been rendered relating to your practice of nursing? *and/or*

   Have you been reported to the National Practitioner Data Bank? *and/or*

   Have your clinical privileges been suspended, revoked, restricted or limited?

   If any of the questions above were answered '**Yes**'*, then -*

   Yes__No__ Have you previously reported/provided the following information to the Louisiana State Board of Nursing? If you answered '**No**' here, and/or had *not* reported/provided the following, then submit with application:

   - *Provide a narrative explanation (dated and signed) with date(s) of incident(s) involved, detailed description of the incident(s) at issue along with description of the surrounding circumstances, information regarding the current status of the Medical Review Panel opinion, civil or medical malpractice suit(s), and any/all other relevant information*.
   - *Enclose photocopies of any/all Medical Review Panel opinions, civil or medical malpractice suit(s), along with any/all related records*

Name of Applicant (provide at top of each page): _____

5. **Yes__No__ Have you been diagnosed with, do you have, or have you had a medical, physical, mental, emotional or psychiatric condition that might affect your ability to safely practice as a Registered Nurse?**

*If the above question was answered '***Yes***', then:*

Yes__No__ Have you previously reported/provided the following information to Board staff or the Recovery Nurse Program? If you answered '**No**' here, and/or had *not* reported/provided the following, then submit with application:

- *Provide a narrative explanation (dated and signed) with date(s) of incident(s) involved, detailed description of the condition(s) at issue, diagnoses, treatment received so far, treatment planned or prescribed, information regarding the current status of your condition(s), date, name and location of any/all treating facility(ies) and/or treating caregiver(s), number of times in treatment, currently-prescribed medication(s), and any/all other relevant information. Include in your statement if you are going to apply, or have applied, for Social Security or insurance disability.*
- *Enclose photocopies of any/all discharge summaries, relevant medical records and/or treatment record.*
- *Written, signed & dated, statement(s) from treating physician(s) addressing current ability to safely practice nursing, and any/all related records must be sent directly to LSBN by the treating physician. (Letter and envelope should indicate ATTN: Reinstatement Department)*

6. **Yes__No__ Have you had a problem with, been diagnosed as dependent upon, or been treated for mood-altering substances, drugs or alcohol?** *and/or*

Have you been diagnosed as dependent upon, addicted to, or been treated for, dependence upon medications?

If either of the above questions were answered '**Yes**'*, then -*

Yes__No__ Have you previously reported/provided the following information to Board staff or the Recovery Nurse Program? If you answered '**No**' here, and/or had *not* reported/provided the following, then submit with application:

- *Provide a narrative explanation (dated and signed) with date(s) of incident(s) involved, detailed description of the condition(s) at issue, diagnoses, treatment received so far, treatment planned or prescribed, information regarding the current status of your condition(s), date, name and location of any/all treating facility(ies) and/or treating caregiver(s), number of times in treatment, currently-prescribed medication(s), and any/all other relevant information. Include in your statement if you are going to apply, or have applied, for Social Security or insurance disability.*
- *Enclose photocopies of any/all discharge summaries, relevant medical records and/or treatment record.*
- *Written, signed & dated statement(s) from treating physician(s) addressing current ability to safely practice nursing, and any/all related records must be sent directly to LSBN by the treating physician. (Letter and envelope should indicate ATTN: Reinstatement Department)*

Name of Applicant (provide at top of each page):_____

Section IV. Practice Attestation

Please check **one** of the following:

_____ **I attest that I have not practiced as a registered nurse in Louisiana during the period that my RN licensure status has been inactive/retired/delinquent.**

OR

_____ **I attest that I have practiced as a registered nurse in Louisiana during the period that my RN licensure status has been inactive/retired/delinquent.**
NOTE - ***Complete the section below in full if you worked without an active license, providing name and address of the employer, the dates worked and fill in the 'Statement of Explanation' section regarding why you had worked without a current/active licensure in Louisiana.***

Name/Address of Employer: _____

_____

Dates of Employment: **from**_____ **to** _____
(*Provide the actual **date** last worked: month/day/year*)

Statement of Explanation: _____

_____

_____

_____

_____

_____

_____

Section V. Attestation / Signature / Identifying Information ** *Use BLUE Ink to Sign Below* **

I hereby apply for reinstatement of my Louisiana Registered Nurse license and attest by my signature below that to the best of my knowledge, information and belief, all statements that I have made are true and correct and that I have not withheld any information that might affect this application. I understand that failure to disclose and/or falsification of any information accompanying or contained on this application will result in denial of relicensure and may result in disciplinary action. I further certify that I am in compliance with the continuing education (CE) and nursing practice requirements for relicensure and agree to supply supporting documents. I hereby authorize the Louisiana State Board of Nursing to conduct a criminal records check and authorize the Louisiana State Police and the Federal Bureau of Investigation to release all criminal record information maintained in their file, which may confirm or deny my eligibility for reinstatement/relicensure.

Signature: _____ (BLUE ink) **Social Security Number**_____

Date: _____ **Date of Birth** _____

NOTE: Attach copies of continuing education (ANCC/BON accredited CE certificates), signed RN Employment Verification form, reinstatement fee, and any letter of explanation (if applicable – see instructions) to this completed & signed reinstatement application and mail to the LSBN office in one (1) envelope.

LOUISIANA STATE BOARD OF NURSING

17373 Perkins Road, Baton Rouge, LA 70810
Phone: (225) 755-7500
www.lsbn.state.la.us

APPLICATION FOR REINSTATEMENT BY ADVANCED PRACTICE REGISTERED NURSE

		2014
LICENSE NO.		**YEAR**

PRINT ALL INFORMATION BELOW (Legal documentation must be provided for name change)
APPLICANT'S CURRENT MAILING ADDRESS & CONTACT INFORMATION:

Applicant's Current Name: _____
Current Mailing Address: _____
City, State & Zip: _____
Home Phone Number: (_____) _____
Cell Phone Number: (_____) _____
E-mail Address:_____

EMPLOYER ADDRESS: Employer Name: _____
Address: _____
City, State & Zip: _____
Employer Phone Number: (_____) _____

APPLICATION MUST BE *SIGNED* WITH BLUE INK. Rest of application must be either typed - or - completed with Blue or Black ink. Read separate instructions fully. Any errors or omissions will delay reinstatement.

Section I. I Hereby Apply For:

_____ **Active Status from Inactive/Retired/Delinquent Status $100.00 fee**

APPROPRIATE FEES MUST BE SUBMITTED ALONG WITH THIS APPLICATION -

- Please read the *full* Instructions for Applying for APRN Licensure by Reinstatement *before* completing and submitting this application to ensure you are eligible to apply.
- **Money Order** or **Bank Cashier's Checks *only***. Personal Checks or Cash are **not** accepted.
- Fees are NOT refundable

Applications not completed within one (1) year from date of submission will be closed and cancelled.

Section II. Current/Primary Employment as an APRN:

Please indicate your anticipated employment as an APRN:

1. Category

____ CNS
____ CNM
____ CRNA
____ NP

2. Clinical Specialty

____ Anesthetist (CRNA)
____ Midwife (CNM)
____ Acute Care NP
____ Adult NP
____ Family NP
____ Gerontological NP
____ Neonatal NP
____ Oncology CNS
____ Pediatric NP
____ Women's Health Care NP
____ Adult Psychiatric & Mental Health CNS
____ Child/Adolescent Psychiatric & Mental Health CNS
____ Community Health CNS
____ Gerontological CNS
____ Home Health CNS
____ Maternal Child CNS
____ Adult Health CNS (formerly Medical – Surgical)
____ CNS in Acute and Critical Care - Adult
____ CNS in Acute and Critical Care - Pediatric
____ CNS in Acute and Critical Care - Neonatal
____ Adult Psychiatric and Mental Health NP
____ Family Psychiatric and Mental Health NP
____ Clinical Nurse Specialist in Pediatric Nursing
____ Other _____

3. Clinical Setting

____ Outpatient Clinic
____ College Student Health Clinic
____ Emergency Department
____ HIV/AIDS Clinic
____ Hospital
____ Nursing Home
____ Pediatric Clinic
____ Physicians Office
____ Private Clinic
____ Medicine Clinic
____ Rural Clinic
____ School Clinic
____ Urban Clinic
____ Women's Health Clinic
____ School of Nursing
____ Other _____

Section III. Advanced National Certification

Note: If originally licensed in Louisiana under the grandfathered provision (Commensurate Requirements) *and not nationally certified*, leave this section (Section III) blank. Complete and attach a "Verification of [Renewal] Reinstatement Requirements for APRNs without National Certification" form (VR-1) and proof of CE requirements, and proceed to Section IV.

If **nationally certified**, then proceed with this section submit documentation of current certification. If certified in more than one specialty area. Indicate advanced national certification as it applies to primary and secondary employment.

For example, you are certified as a Family NP from ANCC and Women's Health Care NP from NCC, but you are employed as a FNP, primary certification would be ANCC and secondary certification would be NCC.

1. National Certifying Organization (Select only one in each column)

Primary	Secondary	
☐	☐	National Board on Certification & Recertification of Nurse Anesthetists (NBCRNA/AANA)
☐	☐	American Midwifery Certification Board (AMCB)
☐	☐	American Academy of Nurse Practitioners (AANP)
☐	☐	American Nurses Credentialing Center (ANCC)
☐	☐	Pediatric Nursing Certification Board (PNCB)
☐	☐	National Certification Corporation of Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)
☐	☐	Oncology Nursing Certification Corporation (ONCC)
☐	☐	American Association of Critical Care Nurses Certification Corporation (AACN)

2. Specialty Area (Select only one in each column)

Primary	Secondary	
☐	☐	Nurse Anesthetist
☐	☐	Certified Nurse Midwife
☐	☐	Acute Care Nurse Practitioner
☐	☐	Adult Nurse Practitioner
☐	☐	Adult-Gerontological Acute Care Nurse Practitioner
☐	☐	Adult-Gerontological Primary Care Nurse Practitioner
☐	☐	Family Nurse Practitioner
☐	☐	Gerontological Nurse Practitioner
☐	☐	Neonatal Nurse Practitioner
☐	☐	Oncology Clinical Nurse Specialist
☐	☐	Pediatric Nurse Practitioner
☐	☐	Women's Health Care Nurse Practitioner
☐	☐	Adult Psychiatric and Mental Health Nursing Clinical Specialist
☐	☐	Child and Adolescent Psychiatric and Mental Health Nursing Clinical Specialist
☐	☐	Community Health Nursing Clinical Specialist
☐	☐	Home Health Clinical Specialist
☐	☐	Adult Health Clinical Specialist (formerly known as 'Medical – Surgical Nursing')
☐	☐	Maternal Child Clinical Specialist
☐	☐	Clinical Nurse Specialist in Acute and Critical Care - Adult
☐	☐	Clinical Nurse Specialist in Acute and Critical Care - Pediatric
☐	☐	Clinical Nurse Specialist in Acute and Critical Care - Neonatal
☐	☐	Adult Psychiatric and Mental Health Nurse Practitioner
☐	☐	Family Psychiatric and Mental Health Nurse Practitioner
☐	☐	Clinical Nurse Specialist in Pediatric Nursing

3. Certification Expiration date: _____ ***We must receive evidence of current certification directly from the certifying body.***

Section IV. Practice Verification

Check one (1) of the following:

_____ I attest that **I have not practiced** as an advanced practice registered nurse in Louisiana during the period that my APRN licensure status has been inactive/retired/delinquent; ***OR***

_____ I attest that **I have practiced** as an advanced practice registered nurse in Louisiana during the period that my APRN licensure status has been inactive/retired/delinquent. (*Submit statement of explanation with employer name/address and dates*)

Section V. Attestation / Signature / Identifying Information. ** *Use BLUE Ink to Sign Below* **

I hereby apply for reinstatement of my Louisiana Advanced Practice Registered Nurse (APRN) license and attest by my signature below that to the best of my knowledge, information and belief, all statements that I have made are true and correct and that I have not withheld any information that might affect this application. I understand that failure to disclose and/or falsification of any information accompanying or contained on this application will result in denial of relicensure and may result in disciplinary action. I hereby authorize the Louisiana State Board of Nursing to conduct a criminal records check and authorize the Louisiana State Police and the Federal Bureau of Investigation to release all criminal record information maintained in their file, which may confirm or deny my eligibility for relicensure.

Signature: _____ (BLUE ink) **Social Security Number_____**

Date: _____ **Date of Birth _____**

Louisiana State Board of Nursing

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APRN EMPLOYMENT VERIFICATION FORM - REINSTATEMENT

INSTRUCTIONS:
This form is to be completed in full by the applicant's ***EMPLOYER*** and **returned to the nurse** seeking reinstatement for the State of Louisiana. The nurse/applicant must submit this completed form along with his/her APRN application and fees as ONE (1) complete packet.

PLEASE TYPE OR PRINT LEGIBLY

This is to certify that _____ is/was employed -
Print RN/APRNs name above

From: _____ To: _____
Hire/Start Date (month/day/year) Last Day Worked or '*Present*' if still employed

As a(n): RN - ☐ NP - ☐ CRNA - ☐ CNS - ☐ CNM - ☐
Other: ☐ - If '***Other***' specify job title in space below and provide list job duties ***together*** with this form.

_____

Is the above Nurse eligible for rehire with your facility/institution: **Yes -** ☐
No - ☐

_____ _____
Date Signature and Title of Supervisor Completing Form

Please **PRINT** or **TYPE** the following information:

NAME/PERSON COMPLETING FORM: _____

EMPLOYER/COMPANY: _____

MAILING ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

Louisiana State Board of Nursing

ADDITIONAL INSTRUCTIONS AND FORMS FOR COMPLETING A CRIMINAL BACKGROUND CHECK FOR REINSTATEMENT FOLLOW THIS DIVIDER PAGE

A Criminal Background Check (CBC) is required for Reinstatement *when*:

- The reinstatement applicant has not held an active Louisiana nursing license for five (5) years or more, ***and/or***

- If otherwise required as directed in Section III, question # 1 of the RN Reinstatement Application. See page 2 of the RN reinstatement application for further details regarding this compliance question.

Please read all questions on the Reinstatement application(s) carefully. Failure to disclose and/or falsification of any information on an application, form(s) or other records submitted to the Louisiana State Board of Nursing is cause for denial of licensure and can result in disciplinary action.

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FINGERPRINT INSTRUCTIONS FOR CRIMINAL BACKGROUND CHECK (CBC)

1) **Authorization Forms**: Complete, sign and date **both** of the following CBC authorization forms and submit to LSBN together with the appropriate licensure application (if applicable), fees, and two (2) fingerprint FBI cards:

   * **CBC1a:** Authorization for Criminal Background Check – Page I
   * **CBC1b:** Authorization for Criminal Background Check – Page II

2) **Fingerprinting**: Contact your state or local police/sheriff's office to inquire about their procedures, fees and locations for fingerprinting services. You will need to be fingerprinted onto two (2) official Federal Bureau of Investigation (FBI) fingerprint cards. If your local law enforcement office does not have FBI cards, Board staff can mail you a set of blank FBI cards upon written request. Fill out the Request for Blank Fingerprint Cards form, indicate which department you will be submitting the CBC (and application, where applicable) at the top, and fax to LSBN. If providing the CBC fingerprints cards & authorization sheets to apply for initial licensure or reinstatement in Louisiana, they must accompany your application.

   - Each of the two (2) FBI cards need a separate and distinct set of your fingerprints. If the agency utilizes an electronic scan system, request that they scan your fingerprints and print the first FBI card, then scan your fingerprints again and print the second FBI card.
   - The following suggestions may improve print quality and ensure LSBN staff receive your CBC results promptly:
     - Hands must be clean and dry. Wash your hands vigorously with warm water and dry thoroughly immediately prior to being fingerprinted.
     - If hands are very dry or cracked, wash hands and apply a touch of moisturizer onto fingertips, removing any excess lotion with paper towel prior to being fingerprinted. This may help raise the ridges for printing.
   - L.A.C.46:XLVII.3330 J-K states:

     J. If the fingerprints are returned from the Department of Public Safety as inadequate or unreadable, the applicant, or licensee must submit a second set of fingerprints and fees, if applicable, for submission to the Department of Public Safety.

     K. If the applicant or licensee fails to submit necessary information, fees, and/ or fingerprints, the applicant or licensee may be denied licensure on the basis of an incomplete application or, if licensed, denied renewal, until such time as the applicant or licensee submits the applicable documents and fee.

   - View both FBI cards before you leave the facility where you're being fingerprinted. If any of the fingerprints are outside the boxes, appear too light, too dark, or obviously smudged - have the technician prepare an extra set of cards and submit **both sets** (all four cards) along with your application. ***Protect both FBI cards from smudges. Do not fold or staple.***
   - All fingerprint cards must be signed by the nurse with all sections filled out completely with the exception of the "employer and address" section.
   - Individuals who are *already licensed Registered Nurses* may have their fingerprints scanned at the LSBN office (LiveScan) between 8:30am and 3:00 pm. Please arrive early to allow time for fingerprint scanning & processing.

3) **Fees due LSBN for CBC:**

   - $42.50 – Payable to Louisiana State Board of Nursing (LSBN) if paper FBI fingerprint cards are submitted

   - OR –

   - $52.50 – Payable to Louisiana State Board of Nursing (LSBN) if coming in person to the LSBN office to have your hands scanned using the LiveScan equipment. (**Licensed Registered Nurses only**).

All fees must be paid by Money Order or Bank Cashier's Check, payable to LSBN

NOTE: If you are submitting to a CBC because you are applying for licensure or permission to enroll in clinical nursing courses, please read the **application instructions** carefully regarding payment of fees. Some application instructions will provide a '*total fee*' to submit with the application which may include the CBC fee noted above.

(Criminal history records check is authorized under the Nurse Practice Act, **Louisiana Revised Statutes 37:920.1**)

Revised: 2/08, 6/11, 3/12

Authorization for Criminal Background Check (CBC) – Page I

****FORMS MUST BE FILLED OUT IN INK AND BE REVIEWED BY SUBMITTING AGENCY/INDIVIDUAL FOR ACCURACY****
******FINGERPRINTS ARE NECESSARY FOR A POSITIVE IDENTIFICATION******

Fees for CBC (money order or bank cashier's check required, payable to LSBN):

- $42.50 – Payable to Louisiana State Board of Nursing (LSBN) if paper FBI fingerprint cards are submitted

- OR –

- $52.50 – Payable to Louisiana State Board of Nursing (LSBN) if coming in person to the LSBN office to have your hands scanned using the LiveScan equipment. (Licensed Registered Nurses only).

***** Refer to your Application Instructions to see if the above CBC cost if already incorporated in the application fee total*****

******PLEASE PRINT (except 'Signature) – USE BLUE OR BLACK INK WHEN FILLING OUT THIS FORM *****

Louisiana State Board of Nursing
FACILITY OR AGENCY

Patricia A. Dufrene, MSN, RN
FACILITY OR AGENCY AUTHORIZED REPRESENTATIVE

Cynthia York, RN, MSN, CGRN
FACILITY OR AGENCY AUTHORIZED REPRESENTATIVE

17373 Perkins Road
MAILING ADDRESS

SIGNATURE OF LSBN AUTHORIZED REPRESENTATIVE

Baton Rouge, LA 70810
CITY STATE ZIP CODE

(225) 755-7500
FACILITY OR AGENCY PHONE NUMBER

Request For: (pick one only)

□ **ALCOHOL AND BEVERAGE COMMISSION**
□ **ALCOHOL BEVERAGE OUTLET**
□ **CASA**
□ **CONCEALED HANDGUNS**
□ **CRIMINAL JUSTICE EMPLOYEE**
□ **DAYCARE**
□ **DENTISTRY BOARD**
□ **DEPARTMENT OF LABOR**
□ **DEPARTMENT OF PUBLIC SAFETY**
□ **EMPLOYERS**
□ **FIREFIGHTERS**
□ **GAMING**
□ **HEALTH CARE PROVIDER**
□ **IMMIGRATION**
□ **JUVENILE DETENTION CENTER**
□ **DEPARTMENT OF INSURANCE**
□ **MANUFACTURED HOUSING**
□ **MEDICAL EXAMINERS**
□ **OCS FOSTER/ADOPTIVE**
□ **OCS PERSONNEL**
□ **OFFICE OF FINANCIAL INSTITUTIONS**
□ **OFFICE OF PUBLIC HEALTH**
□ **PHARMACY BOARD**
□ **POSTSECONDARY EDUCATION**
□ **PRACTICAL NURSING**
□ **PRIVATE ADOPTION**
□ **PRIVATE INVESTIGATORS**
□ **PRIVATE SECURITY**
□ **PUBLIC HOUSING**
□ **PUBLIC TAG AGENT**
☑ **REGISTERED NURSING**
□ **RELIGIOUS ACTIVISTS**
□ **RIVERBOAT PILOTS**
□ **SCHOOL**
□ **SENATE AND GOVERNMENTAL AFFAIRS**
□ **TAXI DRIVERS**
□ **USED MOTOR VEHICLE COMMISSION**
□ **VOLUNTEERS WITH YOUTH SERVING ORGANIZATIONS**

**** Please print all but Signature ****

APPLICANTS NAME: _____
LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME (if different)
{Provide any and all '*other*' Last Names held which are not listed above in the bottom margin of this page}

APPLICANTS SIGNATURE: _____

APPLICANTS SOCIAL SECURITY # _ _ _ - _ _ - _ _ _ _ DATE OF BIRTH: _ _ / _ _ / _ _

DRIVERS LICENSE #:_____& STATE _____ RACE _____ SEX ____

POSITION OR LICENSE APPLIED FOR _____

AUTHORIZATION TO DISCLOSE CRIMINAL HISTORY RECORDS INFORMATION

By my signature above, I hereby authorize the Louisiana State Police to release all pertinent criminal record information maintained in their files, other states files, or the FBI files (if applicable) which may confirm or deny my eligibility with the facility or agency named above.

FORM NBR: CBC – 1a

Authorization for Criminal Background Check (CBC) – Page II

APPLICANT PROCESSING-DISCLOSURE
BUREAU OF CRIMINAL IDENTIFICATION AND INFORMATION
P.O. BOX 66613 (MAIL SLIP A-6)

LSPAPPR/R8.03

LOUISIANA STATE BOARD OF NURSING
AGENCY

NOTICE:
PLEASE PRINT OR TYPE INFORMATION, EXCLUDING ADMINISTRATORS OR AUTHORIZED PERSON SIGNATURE. INCOMPLETE FORMS WILL NOT BE PROCESSED.

17373 Perkins Road
MAILING ADDRESS

Baton Rouge **LA** **70810**
CITY STATE ZIP CODE

Endorsement applicant to provide the following information below:

APPLICANT'S FULL NAME (print) DATE OF BIRTH RACE SEX

SOCIAL SECURITY NUMBER

ALL INFORMATION RELEASED MUST REMAIN STRICTLY CONFIDENTIAL AND ONLY THOSE AUTHORIZED BY LAW TO RECEIVE THIS INFORMATION MAY SUBMIT A REQUEST.

DO NOT WRITE BELOW THIS LINE: (FOR BUREAU OF CRIMINAL IDENTIFICATION AND INFORMATION USE ONLY

NOTICE: The response to your request for a criminal history check is based on a review of the State of Louisiana's criminal history records database as is available at the time of request. This does not preclude the possible existence of conviction information not available in our database.

CRIMINAL HISTORY DETERMINATION:

☐ **RAPSHEET ATTACHED**

☐ **RESPONSE BELOW**

FORM NBR: CBC – 1b

Revised: 2/08, 6/11, 3/12

Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810
Telephone: (225) 755-7500
Credentialing Fax Number: (225) 755-7581
www.lsbn.state.la.us

REQUEST FOR BLANK FINGERPRINT CARDS

I am required to submit to a Criminal Background Check (CBC) as authorized by the Nurse Practice Act, Louisiana Revised Statutes 37:920.1. I am unable to obtain Federal Bureau of Investigation (FBI) cards from my local law enforcement agency; therefore I am requesting two (2) blank fingerprint cards to be mailed to me by the Louisiana State Board of Nursing (LSBN).

Please indicate the department you will later be submitting an application for Louisiana licensure for this request. Check one box below, complete bottom and fax to the number listed above.

☐ **- RN Licensure by Endorsement** (already licensed as an RN outside of Louisiana)

☑ **- RN or APRN Licensure by Reinstatement** (I held a Louisiana RN or APRN license previously)

☐ **- APRN Licensure by Endorsement or Examination**

Full Name: _____

Mailing Address:

_____
Street Address (please include apartment number, if applicable)

_____
City State Zip

Home Phone Number: _____

Work Phone Number (please include extension): _____

Cell Phone Number: _____

E-mail Address: _____

***** Please do <u>not</u> submit your application until you have received and completed the FBI fingerprint cards. Your full CBC packet must accompany your application *****