



APPLICATION FOR
WYOMING REGISTERED NURSE LICENSURE
with **ADVANCE PRACTICE RECOGNITION (APRN)**

All licenses expire December 31 of every EVEN year



This is a Legal Document. By completing and signing this, you certify under

penalty of perjury and subject to the provisions of W.S. 6-5-303 and its penalties, that you have not knowingly submitted false or misleading information to the Wyoming State Board of Nursing on any application for licensure or temporary permit.

INSTRUCTIONS AND GENERAL INFORMATION: (Keep a copy for your records)

Thank you for applying to the Wyoming State Board of Nursing (WSBN). We look forward to welcoming you to our beautiful state! In order to process your application quickly, please follow these instructions. Contact our office with any questions. We will be happy to assist you!

- Complete Application. If you choose not to type in the document, please print neatly in INK.
- You must provide all required information or your application is incomplete. WSBN will hold incomplete applications for one year from the date received.
- For faster notification of your application status, provide an accurate e-mail address.
- There are no refunds for incomplete or withdrawn applications.
- **WSBN is paperless. All licenses, certificates & temporary permits will be available for verification on-line at <http://nursing.state.wy.us/>.**

Requirements:

If you are applying for a registered nurse license by endorsement from another state, relicensure or reactivation you must:

- Be a graduate from any state board-approved nursing education program ;
- Have committed no acts which are grounds for disciplinary action (W.S. 33-21-146), or if you have committed acts, provide adequate documentation for the board to review your case;
- Provide payment (money order, cashier's check, VISA, MasterCard or Discover); and

Graduate Temporary Permit: (Endorsing APRNs are not eligible for a temporary permit)

WSBN *may* issue a non-renewable temporary permit (not to exceed 90 days) if:

1. Official transcripts mailed directly from the Registrar's Office;
2. Proof of having applied for the first national specialty APRN examination offered after graduation and for which you are eligible
3. A letter from the professional (appropriately recognized APRN or licensed physician) who has agreed to supervise your practice as a Graduate APRN. The letter must state understanding of the laws related to the Graduate Temporary Permit and show equivalence between APRN role and supervisor's role/specialty.

A graduate temporary permit shall become invalid if you fail to take and pass the first national specialty APRN certifying examination offered after graduation.

Criminal Background Check:

In accordance with Wyoming Statutes, WSBN requires to criminal background checks before we can issue a license or certificate, even if you had a background check in the past.

Fingerprint cards will be sent to you once the application and fees are received at WSBN. You must return the completed fingerprint cards and WSBN must receive the background check report from the Division of Criminal Investigation before your certificate will be issued.

What you need to get started: (Check off items as you complete them)

_____ A copy of your social security card AND another form of lawful presence (driver's license, birth certificate, passport, or other item listed in application). **If you use your driver's license as proof of lawful presence, it must have the same name as your social security card.**

_____ A form of payment WSBN accepts (money order, cashier's check, VISA, MasterCard or Discover);

_____ Hold or are applying for a current license as a registered professional nurse in Wyoming with this application;

_____ Submit verification from your original state of licensure;

_____ Provide an official transcript confirming completion of a master's degree in nursing with preparation in an advanced practice specialty area OR completion of an APRN education program PRIOR to January 1, 1999;

_____ Provide documentation verifying national certification in a specific specialty area of advanced practice, accepted by the board;

_____ Submit evidence of meeting required continued competency

_____ **Fingerprint cards will be sent to you once your application and fees are received;** once you receive them provide fingerprints, following instructions for chain of custody and return to WSBN.

If you would like your fingerprint cards mailed to a different address than what is listed on your application, please provide a self-addressed envelope (8" X 11").

Please advise us of any address changes, thank you.

FEES

(All fees are non-refundable and subject to change)

You must include payment (**Cashier's Check, Money Order, VISA, MasterCard or Discover**) with your application.

WSBN CANNOT ACCEPT PERSONAL CHECKS OR CASH.



Name of Applicant (PLEASE PRINT):

If checked, enter cost in "Amount" Column	Cost	Amount
Mandatory Criminal Background check	\$ 60.00	\$ 60.00
RN Endorsement	\$ 135.00	
APRN Recognition (First Recognition) Note: Must also pay RN Application Fee if not currently licensed in Wyoming	\$ 120.00	
APRN Additional Recognition(s) for Second and subsequent recognitions, cost per recognition	\$ 70.00	
APRN Prescriptive Authority	\$ 70.00	
MANDATORY priority processing fee if paying by VISA, MasterCard or Discover	\$ 5.00	\$ 5.00
TOTAL amount to pay:		

Name, Address, and Phone Number of Individual Paying (PLEASE PRINT):

Licensee Paying Third Party Paying

<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	Card Number and Three Digit Security Code (on back of card): <div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>	Expiration Date:
	Security Code: <input type="text"/> <input type="text"/> <input type="text"/>	

NOTE: Depending on office volume, requests could take up to 14 business days to process, providing application/request is COMPLETE.

By signing below, I authorize the Board of Nursing to debit my credit card for the total amount indicated above.

Signature: _____ Date: _____

Please help us to provide you with speedy customer service; review your application one more time to make sure you have submitted all the required documents and correct payment amount.

Thank you for applying for an Advanced Practice Registered Nurse license with the Wyoming State Board of Nursing! We look forward to having you join us in fulfilling our mission: To serve and safeguard the people of Wyoming through the regulation of nursing education and practice.

RETURN YOUR COMPLETE APPLICATION AND PAYMENT TO:

Wyoming State Board of Nursing
130 Hobbs Avenue – Suite B
Cheyenne, WY 82002

This application is for REGISTERED NURSE LICENSURE with ADVANCE PRACTICE RECOGNITION

1) Check the box that best describes you:

- RN License with Advance Practice recognition by Endorsement (Currently licensed in another jurisdiction)
 APRN Recognition by Examination (Current RN license and a recent graduate of a nationally accredited APRN education program)
 I am applying for a **graduate** temporary permit and have enclosed proof of having applied for the first national specialty APRN examination offered after graduation. Temporary permits are good for 90 days from date of issue and will be issued upon receipt of complete application unless a specific start date is provided.

Requested start date: _____

2) Personal Information:

Social Security Number _____ Date of Birth _____ Male/Female **F** - -

Last Name _____ First Name _____ Middle Name _____ Maiden Name _____

Mailing Address _____ City _____ State _____ Zip _____

Phone _____ Work Phone _____ E-mail Address _____

3) Lawful Presence: (Described in instructions, page 1)

You must provide evidence of your lawful presence in the U.S. to be granted professional licensure. **Please provide a copy of your Social Security Card and one of the following:**

- U.S. Birth Certificate INS Form I-551 (commonly known as a “green card/visa”) Exp. Date: _____
 U.S. Passport Driver’s License
 Certificate of Naturalization Other documentation that shows lawful admittance into the United States
 Certificate of Citizenship

4) Check your highest NON-NURSING education

- High School Diploma Associate Degree Baccalaureate Degree Master’s Degree Doctorate Degree

5) Name and Location of Nursing Education Program completed for your RN:

Name of nursing program: _____ City and State: _____

Date Enrolled _____ Date Completed _____ Degree Earned: _____
(month and year) (month and year)

Name and location of any additional nursing education: _____

City _____ State: _____ Date Enrolled _____ Date Completed _____

Degree Earned: _____

Did you receive funding for your RN or APRN education program from Wyoming by Workforce Services, a healthcare facility, federal grant or similar funding program? Yes No

6) I meet continued competency requirements by ONE of the following:

- | | |
|--|--|
| <input type="checkbox"/> I worked a minimum 500 hours as an APRN in the last two (2) years | <input type="checkbox"/> Completion of a refresher course in the last five (5) years (submit proof of completion) |
| <input type="checkbox"/> I worked a minimum 1600 hours as an APRN in the last five (5) years | <input type="checkbox"/> National Certification in a specialty area in the last five (5) years (submit copy of National Certification) |
| <input type="checkbox"/> Twenty (20) continuing education hours in the last two (2) years (submit proof of completion) | <input type="checkbox"/> Passing NCLEX within the last five (5) years |

7) APRN Applicants requirements: The transcripts must be received before APRN recognition can be issued.

- Formal APRN Educational Program: Request an official transcript be sent directly to the WSBN from your Advanced Practitioner Program verifying date of completion.
- National Certification: Enclose a copy of your current certification/re-certification document with application.

Name and location of COMPLETED APRN educational program:

NAME OF PROGRAM, CITY AND STATE	DATE GRADUATED (Month and Year)	CERTIFICATE/DEGREE GRANTED
		<input type="checkbox"/> Certificate (Prior to 1999) <input type="checkbox"/> Master's Degree <input type="checkbox"/> Post Master's Degree <input type="checkbox"/> Doctorate Degree

National Certification:

Name of National Certifying Body	Certification Expiration Date	Primary Specialty Area(s)

8) Prescriptive Authority:

I AM APPLYING FOR PRESCRIPTIVE AUTHORITY BY SUBMITTING:

1. Evidence of having completed thirty (30) contact hours of education in pharmacology and clinical management of drug therapy or pharmacotherapeutics within the five year period immediately before the date of this application.

9) Licensure:

List ALL states (including Wyoming) in which you are currently or have been licensed or certified. Indicate license/certificate number(s) and the name(s) in which license/certificate was issued. Attach a separate sheet if necessary.

State	License Type	Legal Name in Which License/Certificate was Issued	Current Status (Active, Inactive, Expired)	Original State of Licensure?
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes

10) Employment:

FIVE YEAR EMPLOYMENT HISTORY, STARTING WITH CURRENT OR MOST RECENT

- **Employment information must be complete.** Attach a separate sheet if necessary.
- Include dates of unemployment, travel, school, homemaker, etc. **Do not leave any period of time unaccounted for or the application will be returned to you for completion.**
- If employed as a traveling nurse, indicate the individual agency from which you have or are accepting assignments/employment.

1. BEGINNING DATE _____ END DATE _____ HOURS PER WEEK _____
(Month and Year) (Month and Year)

EMPLOYER NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

POSITION _____ SUPERVISOR _____

2. BEGINNING DATE _____ END DATE _____ HOURS PER WEEK _____
(Month and Year) (Month and Year)

EMPLOYER NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

POSITION _____ SUPERVISOR _____

3. BEGINNING DATE _____ END DATE _____ HOURS PER WEEK _____
(Month and Year) (Month and Year)

EMPLOYER NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

POSITION _____ SUPERVISOR _____

4. BEGINNING DATE _____ END DATE _____ HOURS PER WEEK _____
(Month and Year) (Month and Year)

EMPLOYER NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

POSITION _____ SUPERVISOR _____

5. BEGINNING DATE _____ END DATE _____ HOURS PER WEEK _____

(Month and Year)

Applicant Name: _____

(Month and Year)

EMPLOYER NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

POSITION _____ SUPERVISOR _____

6. BEGINNING DATE _____ END DATE _____ HOURS PER WEEK _____
(Month and Year) (Month and Year)

EMPLOYER NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

POSITION _____ SUPERVISOR _____

IF YOU NEED MORE ROOM TO COMPLETE YOUR FIVE YEAR EMPLOYMENT HISTORY, PLEASE ATTACH A SEPARATE SHEET

<p>Are you currently employed in nursing:</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Full time</p> <p><input type="checkbox"/> Part time</p> <p><input type="checkbox"/> Retired</p> <p><input type="checkbox"/> Volunteer</p>	<p>If you are currently employed in nursing check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Acute Care (Hospital)</td> <td><input type="checkbox"/> Nursing Education</td> <td><input type="checkbox"/> Telephonic</td> </tr> <tr> <td><input type="checkbox"/> Assisted Living</td> <td><input type="checkbox"/> Private Clinic</td> <td><input type="checkbox"/> Traveling Agency</td> </tr> <tr> <td><input type="checkbox"/> Case/Disease Management</td> <td><input type="checkbox"/> Public Clinic</td> <td><input type="checkbox"/> Unemployed</td> </tr> <tr> <td><input type="checkbox"/> Doctor's Office</td> <td><input type="checkbox"/> Public Health</td> <td><input type="checkbox"/> Utilization Review</td> </tr> <tr> <td><input type="checkbox"/> Home Health</td> <td><input type="checkbox"/> School Nurse</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Long Term Care (Nursing Home)</td> <td><input type="checkbox"/> State Facility</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Student</td> <td></td> </tr> </table>	<input type="checkbox"/> Acute Care (Hospital)	<input type="checkbox"/> Nursing Education	<input type="checkbox"/> Telephonic	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Private Clinic	<input type="checkbox"/> Traveling Agency	<input type="checkbox"/> Case/Disease Management	<input type="checkbox"/> Public Clinic	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Doctor's Office	<input type="checkbox"/> Public Health	<input type="checkbox"/> Utilization Review	<input type="checkbox"/> Home Health	<input type="checkbox"/> School Nurse	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Long Term Care (Nursing Home)	<input type="checkbox"/> State Facility	_____		<input type="checkbox"/> Student	
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	<input type="checkbox"/> Student																					

11) VOLUNTEER OPTIONS (You are not required to complete this section):

WYOMING MEDICAL REVIEW PANEL

(Wyoming Residents with at least two (2) years nursing experience only):

WYO. STAT. 9-2-1513 through 9-2-1523 created the Medical Review Panel. All malpractice claims against a health care provider must be reviewed by the Medical Review Panel prior to the complaint being filed in any court. The Panel is composed of twelve (12) members. Members are selected by the Attorney General's Office from volunteers.

YES, I would like to serve on this panel.

NO, I do not wish to serve on this panel.

WYOMING NURSE ALERT SYSTEM VOLUNTEER REGISTRATION

If you would like to participate in a statewide system that will identify nurses willing to be mobilized to serve as volunteers during time of public health threats, infectious disease outbreaks, biological terrorism, and/or other disasters or emergencies in Wyoming, visit <https://vol.wyoming.gov/VolunteerMobilizer/> to sign up.

12) History Information:

General Information:

- Wyoming Law does not have a time limit on disclosures of past convictions.
- Every application is reviewed on an individual basis.
- Fingerprints / Background Check reveal:
 - All charges in all states regardless of your age at time of offense
 - Any charges (even charges you were told were dismissed or expunged)
- The Licensing Department performs the investigation & assembles materials/information to send to Application Review Committee (ARC). Members of the ARC review all materials, ask for more information if needed and make the decision.
- The ARC considers the following:
 - Passage of time – how recent the crime(s) took place;
 - Repeated, habitual crimes;
 - Felony versus misdemeanor (although the nature of the crime is the primary consideration);
 - Compliance with the court orders (probation, payment of fines, attendance at anger management or driving classes, evaluations, etc.);
 - Results of evaluations (substance abuse evaluations, anger evaluations, etc.)
 - How the crime relates to nursing practice and public safety (for example, a history of domestic violence may be considered a risk for harming a vulnerable patient); and
- All requirements imposed from discipline from other State Boards of Nursing against your license/certification must be completed before applying to WSNB.
- It takes a significantly longer period of time to process your application if you have disclosed a discipline/compliance issue. It takes even longer if you have failed to disclose and the issue is revealed through your criminal background check.

Court Documents:

- The ARC requires all court documents from the beginning of the arrest to the final disposition of your case, even if the charge(s) was pled down to a lesser charge, deferred, dismissed, etc. Failing to provide complete documentation only delays the process.
- The ARC requires the following court documents:
 - Charging document; sometimes called the information sheet;
 - Judgment and Sentencing;
 - Proof and compliance with the court orders:
 1. Court fines were paid;
 2. Probation completed without problems; **if you are currently on probation e-mail wsbn-info-licensing@wyo.gov and provide your contact information, we will contact you to discuss your individual situation;**
 3. Classes attended; and
 4. Evaluations completed and subsequent action on that evaluation.

Personal Statement (a SIGNED statement in your own words):

- A good personal statement describes:
 - The month and year of the incident
 - Legal or court action taken against you
 - What you have learned
 - How you will assure the ARC that this type of behavior will not happen again
 - Full description of the incident
 - Treatment and outcome of treatment if applicable (i.e. mental health, substance abuse, etc.)
 - How you have changed, specifically, what changes have you made in your behavior and decision-making as a result of your criminal past
 - Signature and Date
- Do not simply list out the charges; this will be rejected by the ARC and cause significant delays and may result in the ARC not granting a certificate /license.
- Please visit the discipline tab on our website at: <http://nursing.state.wy.us> for an example of a personal statement that meets the elements required by the ARC.

All questions must be answered by the applicant. If you fail to answer each and every question and provide necessary documentation for any "Yes" answer the processing of your application will be significantly delayed. Your application is INCOMPLETE until all required documentation is received.

1. Has any disciplinary action been taken or is pending (i.e. open investigation) against you from a LICENSING AUTHORITY?
 No Yes If "YES", provide: • Personal Statement • Documentation of disciplinary action
2. Have you ever been investigated or charged with ABUSE, NEGLECT OR MISAPPROPRIATION OF PROPERTY?
 No Yes If "YES", provide: • Personal Statement • Documentation of disciplinary action
3. Has your application for examination or licensure ever been DENIED BY A LICENSING AUTHORITY?
 No Yes If "YES", provide: • Personal Statement • Documentation of the denial action
4. Do you have a physical or mental disability which renders you unable to perform nursing services or duties with reasonable skill and safety and which may endanger the health and safety of persons under your care?
 No Yes If "YES", provide: • Personal Statement • Progress report from counselor/physician
• Discharge summary/aftercare plan from hospitalizations (IF you were hospitalized)
5. Are you now or have you in the past five (5) years been addicted to any controlled substance, a regular user of any controlled substance with or without a prescription, or habitually intemperate in the use of intoxicating liquor?
 No Yes If "YES", provide: • Personal Statement • Progress report from counselor/physician
• Discharge summary/aftercare plan from hospitalizations (IF you were hospitalized)
6. Have you been terminated or permitted to resign in lieu of termination from a nursing or other health care position because of your use of alcohol or use of any controlled substance, habit-forming drug, prescription medication, or drugs having similar effects?
 No Yes If "YES", provide: • Personal Statement • Progress report from counselor/physician
• Discharge summary/aftercare plan from hospitalizations (IF you were hospitalized)
7. Have you ever been arrested, convicted, pled guilty to, pled nolo contendere to, received a deferment, or have charges pending against you for any crime including felonies, misdemeanors, municipal ordinances, and/or any military code of justice violations, including driving under the influence of any intoxicating substance? Do not include non-moving traffic violations or moving violations which did not involve alcohol or substance impairment.
 No Yes If "YES", provide a Personal Statement and court documents including:
• Information Sheet or Ticket • Judgment and Sentencing
• Proof of compliance with the following (if applicable):
 - Court Order
 - Probation Completion
 - Evaluation Completed and Subsequent Action on that Evaluation
 - Fines Paid
 - Classes Attended
 - Proof that the case is closed

SIGNATURE REQUIRED: I certify under penalty of perjury and subject to the provisions of W.S. 6-5-303 and its penalties, that I have not knowingly submitted false or misleading information to the Wyoming State Board of Nursing on any application for licensure or temporary permit. I understand the WSBN reserves the right to verify any information in this application.

Applicant's Signature: _____ **Date:** _____

Wyoming State Board of Nursing
130 Hobbs Avenue, Suite B, Cheyenne, WY 82002
VERIFICATION OF LICENSURE

If you are endorsing from another state: Complete the top of this page and forward it to the state in which you were originally licensed or if your original state of licensure participates in Nursys® online verification go to www.nursys.com and follow instructions for Nursys® registration. There may be fees associated with the verification required on this form. Contact your state of original licensure for fee information before forwarding this form to them for completion.

Last Name: _____ First Name: _____ Middle Initial: ___ Maiden Name: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Basic Nursing Education Program: _____ Social Security Number: _____

Name: _____ Original License Number: _____ Date Issued _____

I hereby authorize the _____ to furnish to the Wyoming State Board of Nursing the information below. (Name of State Board of Nursing to which form is being sent)

Date: _____ Signature: _____

LICENSING AGENCY:
This is to certify that the above-named individual was issued license number: _____
Date of Issuance: _____
To Practice:
 Registered Nursing Practical Nursing
IF YES TO ANY OF THESE QUESTIONS, PLEASE ATTACH EXPLANATION
Has this license ever been encumbered in any way (revoked, suspended, restricted, limited, placed on probation)?
 Yes No
Under current investigation?
 Yes No
Action Pending?
 Yes No

Examination Results	<input type="checkbox"/> NCLEX-RN	<input type="checkbox"/> NCLEX-PN	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail	Current License Status
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Number of times examination written: _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed
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Name of Nursing Education Program Completed	Year of Graduation
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Location (City and State) _____

SEAL	Signature: _____ Title: _____ State: _____ Date: _____
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