CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF NURSING

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR REINSTATEMENT OF RN OR LPN LICENSE
INSTRUCTION SHEET

Follow instructions carefully.
You must answer *all* questions unless the instruction says to skip them.
Do not leave answers blank if the instruction says to enter them. If an answer is "none," enter *None.*
Incomplete applications will be rejected.

When to File Reinstatement Application

File the *Application for Reinstatement* form when you want to practice in Delaware and you **either**:

- hold a Delaware license that is in *inactive* status, **or**
- previously held a Delaware license that has *expired* and the late renewal period has ended.

If you are *currently* licensed in another compact state (listed below), file this application *only if* you are moving to a *non*-compact state or to Delaware.

COMPACT STATES
Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin

Before completing this application, you must:

- meet the practice requirement, **or**
- complete a *Board-approved* refresher program.

Section 6.6 of the Rules and Regulations explains these requirements.

For information about reinstating Advanced Practice Nurse licenses, see *Application for Licensure as an Advanced Practice Nurse*.

Requirements for All Applicants

☐ Submit completed, signed and notarized *Application for Reinstatement of RN or LPN License*.

- If your name has changed since you were previously licensed in Delaware, enclose a copy of a legal document changing your name (e.g., marriage certificate, divorce decree).
- **Follow instructions carefully. You must answer *all* questions unless the instruction says to skip them. Do not leave answers blank if the instruction says to enter them. If an answer is "none," enter *None. Incomplete applications will be rejected.***
- Read the AFFIDAVIT section and sign the application in front of a notary public. Forms that are unsigned or not notarized will be rejected.

☐ Enclose the processing fee by check or money order made payable to "State of Delaware."

- Applications submitted without this processing fee will be rejected.

☐ Enclose a copy of your driver's license or official identification card from the Division of Motor Vehicles.

- The state (or other jurisdiction) on the identification you provide is considered your home state of residence.
- If you don't have a driver's license or official identification from the Division of Motor Vehicles, you may submit a voter registration card, federal tax return, military form 2058 or a Form W-2 showing your home state of residence.

☐ If you are currently licensed in another state or jurisdiction, enclose a photocopy of *each current* nursing license.

- License must show an expiration date.
- If there is a signature section on your license, sign it before copying.

☐ **Complete the *Authorization for Release of Information* form to request a State of Delaware and Federal Bureau of Investigation criminal background check. Follow the instructions on the authorization form to arrange to be fingerprinted.** You must complete this requirement *even if* you recently had a criminal background check done for some other reason.

☐ Arrange for the Board office to receive *Nursing Reference Form(s)* as follows*:*

- If you have been employed *as the same type of nurse for which you are applying* for at least the past six months, send a form to *each* nursing employer where you worked during the past six months.
- If you have ***not*** been employed *as the same type of nurse for which you are applying* for at least the past six months ***but*** you graduated from your nursing program within the past two years, send a form to your nursing school for completion.
- If you have ***not*** been employed for at least the past six months and you did not graduate from nursing school within the past two years ***but*** you were employed *as the same type of nurse for which you are now applying* within the past five years, send a form to your most recent nursing employer(s) where you worked for at least six months.
- After completing the form, the employer(s) (or nursing school) must return the form by mail *directly* to the Board office. Forms received from you will be rejected.
- A reference form is ***not*** required if you have:
  - ***not*** been employed *as the same type of nurse for which you are now applying* in the past five years
  - completed a Board-Approved Refresher Course in the past two years.

☐ Complete the *Verification of Continuing Education* form following the instructions on the form.

- Enter all courses/programs you have completed over the past two years.
- RN's are required to complete 30 contact hours. LPN's are required to complete 24 contact hours.

☐ Enclose certificates of completion for the courses/programs you list on the *Verification of Continuing Education* form.

- Certificates must show a date, number of credit hours awarded, and a signature of the provider. Transcripts are also acceptable.
- If you do not submit a completion certificate or transcript, you will not receive credit for the course/program.

☐ If you have never been issued a United States Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.

The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Temporary Permit for RN or LPN

For information on applying for a temporary permit, see *RN/LPN Temporary Permit*. *Carefully read the instructions about when you may apply.* **Do *not* begin orientation or employment until you are assigned a temporary permit number.**

OFFICE USE ONLY
DDB________________
R CBC CE
CCL EXPIRES ____________
ID _________

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STATE OF DELAWARE

BOARD OF NURSING

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APPLICATION FOR REINSTATEMENT OF RN OR LPN LICENSE

Answer *all* questions unless the instruction says to skip them.
Do not leave answers blank if the instruction says to enter them. If an answer is "none," enter *None.*

TYPE OF APPLICATION

1. Select the item that describes your situation:
   - ☐ I previously held a Delaware RN or LPN license that is now ***expired*** and the late renewal period has ended.
   - ☐ I hold a Delaware RN or LPN license that is in ***inactive status***.

2. Enter type and number of Delaware license you wish to reinstate:
   - ☐ Registered Nurse – License Number: **L1-**________________ Expiration Date: ________________
   - ☐ Licensed Practical Nurse – License Number: **L2-**________________ Expiration Date: ________________

IDENTIFYING AND CONTACT INFORMATION

3. Full Name: ____________ (Last) ____________ (First) ____________ (Middle) ____________ (Maiden)

4. Other Names Used: None ☐ ____________ ____________ ____________

   If your name was different when you held a Delaware license, enter that name here and submit a legal document showing the name change (e.g., marriage certificate, divorce decree).

5. Date of Birth (month/day/year): ______________________ Gender: Male ☐ Female ☐

6. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: ____________
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

7. Enter your *State or Jurisdiction of Residence*: ______________________

   Enclose a copy of your driver's license or an identification card issued by the Division of Motor Vehicles showing this state or jurisdiction as your residence. See the Instruction Sheet if you have neither of these types of identification.

8. Mailing Address: ____
   ____________________ (City) ____________ (State) ________ (Zip)

9. Phone: ____________ (daytime) ____________ (evening or cell) Email: None ☐ ______________________

LICENSURE HISTORY – In this section, jurisdiction means State, District of Columbia, U.S. territory or country.

10. Have you ever been denied nursing licensure in Delaware or other jurisdiction? Yes ☐ No ☐ If yes, where?
    ____________________ **Enclose a copy of the legal documents.**

11. Have you ***ever*** held a nursing license *of any kind* in *any state or jurisdiction other than Delaware* – whether in the U.S. or any another country? Yes ☐ No ☐ If yes, enter the following information about *each* license that you have held. Enclose additional sheets if needed. If no, continue with next question.

RN or LPN?	JURISDICTION (state, territory, or other country)	LICENSE NUMBER	EXPIRATION DATE	CURRENT LICENSE STATUS
RN ☐ LPN ☐				
RN ☐ LPN ☐				
RN ☐ LPN ☐				

Enclose copy of each *current* nursing license you now hold.

12. Are any of your nursing licenses currently under investigation? Yes ☐ No ☐ If yes, where? ________________ ____________________ **Enclose a copy of the legal documents**.

13. Have any of your nursing licenses ever been disciplined, including revocation, suspension, probation, voluntary surrender, limitation or letter of reprimand? Yes ☐ No ☐ If yes, If yes, where? ____________________ **Enclose a copy of the legal documents**.

NURSING PRACTICE

14. Have you practiced nursing in the past five years? Yes ☐ No ☐ If no, skip to the next question. If yes, complete the following about your ***nursing*** employment for the past ***five*** years. (If you need more room, enclose additional sheets.)

RN or LPN?	EMPLOYER	ADDRESS (city, state)	EMPLOYMENT DATES	
			From	To
RN ☐ LPN ☐				
RN ☐ LPN ☐				
RN ☐ LPN ☐				

- **If you have been employed for at least the past six months, arrange for the Board office to receive *Nursing Reference Forms directly* from each nursing employer where you worked during the six months.**
- **If you have *not* been employed for at least the past six months *but* you graduated within the past two years, arrange for the Board office to receive a *Nursing Reference Form directly from your* nursing school.**
- **If you have *not* been employed for at least the past six months *and* you did not graduate from nursing school within the past two years *but* you were employed within the past five years, arrange for the Board office to receive *Nursing Reference Forms directly* from your most recent nursing employer(s) where you worked for at least six months.**

15. Did you graduate from a Board of Nursing approved nursing education program within the past two years? Yes ☐ No ☐ If yes, skip to the **DISCLOSURES** section. If no, continue to the next question.

16. Have you completed a Refresher Course in the past two years? Yes ☐ No ☐ If yes, **submit proof of course completion** and skip to the **DISCLOSURES** section. If no, continue to the next question**.**

17. Which of the following describes your nursing practice? Check one:

☐ I have practiced nursing AT LEAST 1000 hours during the past five years.

☐ I have practiced nursing AT LEAST 400 hours during the past two years.

☐ I have completed an alternate supervised practice plan. **Submit your evaluation.**

☐ None of the above describes my practice. **Enclose a written explanation.**

DISCLOSURES

18. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐ If yes, explain: ____

    ____

    Arrange for the Board office to receive a State of Delaware and Federal Bureau of Investigation criminal background check following the instructions on the *Authorization for Release of Information* form.

19. Are criminal charges pending against you in any jurisdiction? Yes ☐ No ☐ If yes, explain below and **enclose copies of any legal documents**: ____

    ____

20. Are you now, or have you *ever* been, dependent on the use of alcohol, stimulants, or habit-forming drugs? Yes ☐ No ☐ If yes, explain: ____

    ____

DUTY TO REPORT

21. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

22. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

23. To obtain a license in Delaware, you must certify that you understand that you have a mandatory duty to report any unsafe nursing practice to the Board of Nursing and to report any unsafe practice conditions to the recognized legal authorities.

    I certify that I have read and understand Section 7.3.1.6 of the Board of Nursing's Rules and Regulations and that I understand my *duty to report*. Yes ☐ No ☐

If Board review of your application is required, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date in order to assure consideration of your application at the meeting:
- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your permanent license (whether or not a temporary license has been issued).

AFFIDAVIT

The law regulating the practice of nursing in Delaware, 24 *Del. C*. §1922 (a), “Grounds for Discipline,” provides that the Board of Nursing may revoke or suspend any license to practice nursing, refuse a license or re-licensing or otherwise discipline a licensee upon proof that a licensee or former licensee is guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing.

The applicant, being duly sworn, says that he/she is the person referred to in the foregoing application for licensure as registered/licensed practical nurse in the State of Delaware, that he/she meets the requirements for licensure, that the statements therein contained are true and that he/she has read and understands this affidavit.

APPLICANT SIGNATURE: ____________________________________ Date: ________________

County of _______________ State of __________________________

Sworn to before me and subscribed in my presence this __________________day of _________________2_______,

Notary Public: ____________________________________

SEAL

My commission expires: ________________

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED PROCESSING FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the Federal Bureau of Investigation website at www.fbi.gov – click *Stats & Services*, then *Identity History Summary Checks*, then *FD-258 Fingerprint Card*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order **(*personal checks are not accepted*)** for $69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

STATE OF DELAWARE

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRITICAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

☐ Adult Entertainment
☐ Charitable Gaming Vendor
☐ Chiropractic
☐ Dental
☐ Massage
☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
☐ Nursing (RN, LPN, APN)
☐ Nursing Home Administrator
☐ Occupational Therapy
☐ Optometry
☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
☐ Physical Therapy/Athletic Trainer
☐ Podiatry
☐ Psychology
☐ Real Estate Appraiser (includes Appraisal Management Company)
☐ Speech/Hearing
☐ Social Work
☐ Texas Hold'em Individual
☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers)

Print your current full name:

Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: ______________________________ **Date**: ______________

Phone: Home ____________________ Work ____________________

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 7/2015

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STATE OF DELAWARE

BOARD OF NURSING

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NURSING REFERENCE FORM

INSTRUCTIONS

Application by Endorsement or Reinstatement

If applying for nursing licensure by endorsement or reinstatement, arrange for the Board office to receive this form as follows:

- If you have been employed *as the same type of nurse for which you are applying* for at least the past six months, complete the APPLICANT INFORMATION section and send a form to *each* nursing employer where you worked during the past six months.
- If you have ***not*** been employed *as the same type of nurse for which you are applying* for at least the past six months ***but*** you graduated from your nursing program within the past two years (24 months), complete the APPLICANT INFORMATION section and send the form to your nursing school for completion.
- If you have ***not*** been employed for at least the past six months ***and*** you did not graduate from nursing school within the past two years (24 months) ***but*** you were employed *as the same type of nurse for which you are applying* within the past five years (60 months), complete the APPLICANT INFORMATION section and send a form to your most recent nursing employer(s) where you worked for at least six months.

Application by Examination

If applying for nursing licensure by examination, complete the APPLICANT INFORMATION section and send the form to your nursing school for completion.

APPLICANT INFORMATION – to be completed by applicant

1. Type of Application: ☐ RN ☐ LPN
2. Applicant Name: ______________________ ______________ ____________
   Last First Middle
3. Address: ______________________ ____________ ________ ______
   Street City State Zip
4. Social Security Number: ____________________
5. Phone: ____________________ Email: ____________________
6. Employer/School Name: ________________________________
7. Employer/School Address ______________ ____________ ________ ______
   Street City State Zip

AUTHORIZATION FOR RELEASE OF INFORMATION

As an applicant for nursing licensure in the State of Delaware, I hereby authorize release of reference information about my nursing employment and about my nursing education at the above named institution.

APPLICANT SIGNATURE: ________________________ Date: ______________

The Board office will accept only forms it receives directly from the employer/school.
Forms returned by the applicant will not be accepted.
FAXED FORMS WILL NOT BE ACCEPTED.

REFERENCE – to be completed by applicant's nursing employer or nursing school

The above-named applicant has applied for nursing licensure in Delaware. Please complete the appropriate box below and sign where indicated. Thank you for your assistance.

NURSING EMPLOYER

Applicant Name: ______________________________

Name of Employer: ______________________________

The applicant was employed as: LPN ☐ RN ☐

From: ________________ To: ________________ Currently Employed ☐
Month/Day/Year Month/Day/Year

Based on this person's performance, would you recommend her/him for licensure? **Yes** ☐ **No** ☐

If you checked no, please explain. Your answer is a factor in determining eligibility for Delaware licensure.

____

____

Name of Person Completing Form: ________________ Title: ________________

Signature: ______________________________ Date: ____________

Phone: ________________ Email: ________________

OR

NURSING SCHOOL

Applicant Name: ______________________________

Name of School: ______________________________

Graduation Date (month/day/year): ____________ Degree Awarded: ____________

Which program did the applicant complete? ☐ RN Program ☐ LPN Program

RN Program: Did the program provide at least 400 hours of clinical experience? Yes ☐ No ☐

LPN Program: Did the program provide at least 200 hours of clinical experience? Yes ☐ No ☐

Name of Person Completing Form: ________________ Title: ________________

Signature: ______________________________ Date: ____________

Phone: ________________ Email: ________________

The Board office will accept only forms it receives directly from the employer/school. Mail form to:

Board of Nursing
Cannon Building, Suite 203
861 Silver Lake Blvd.
Dover DE 19904

Forms returned by the applicant will not be accepted.
FAXED FORMS WILL NOT BE ACCEPTED.

DELAWARE BOARD OF NURSING

VERIFICATION OF CONTINUING EDUCATION

Complete and sign this form. Enclose it with your *Application for Reinstatement.*

- **You must list your continuing education (CE) on this form *in addition to* sending the completion certificates.**
- Print or type all entries.
- List complete dates (month/day/year) as stated on certificate, complete course names, complete names of providers (not the presenters) and number of contact hours awarded for continuing education in the chart below. Additional space is on page 2. Initials for courses and providers cannot be accepted.
- **Sign and date in the space provided.**
- **Submit a copy of the completion certificate for each course you list. Certificates must show a date, number of credit hours awarded and signature of the provider. Transcripts are also acceptable.**

IDENTIFYING AND CONTACT INFORMATION

Name: ________________________ ________________________ __________ DE Nursing License Number: ______________________
Last First MI

Address: ________________________________ ____________________ __________ __________
Street City State Zip

CONTINUING EDUCATION REQUIREMENT

Are you enrolled in a nursing degree program? Yes ☐ No ☐

Check one:

☐ I am a Licensed Practical Nurse. I am required to submit **24** hours of continuing education.
☐ I am a Registered Nurse. I am required to submit **30** hours of continuing education.

DATE month/day/year	NAME OF COURSE/PROGRAM/CONFERENCE (Do not use initials.)	PROVIDER NAME (NOT Presenter or Approver) (Do not use initials.)	CONTACT HOURS 1 college credit =5 contact hrs

Revised 7/2015

DELAWARE BOARD OF NURSING

VERIFICATION OF CONTINUING EDUCATION

You may duplicate this page if needed.

DATE month/day/year	NAME OF COURSE/PROGRAM/CONFERENCE (Do not use initials.)	PROVIDER NAME (NOT Presenter or Approver) (Do not use initials.)	CONTACT HOURS 1 college credit =5 contact hrs

I certify that the information contained in this document is true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT: ________________________________ **Date:** ____________________

Revised 7/2015