

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 **2015 Application for Reinstatement by Advanced Practice Registered Nurse (APRN)** and required forms. Completed applications and forms must be **mailed** to the Louisiana State Board of Nursing (LSBN) 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 APRN 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. 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 cannot be processed.

Indicate below the documents being submitted to meet requirements for licensure reinstatement:

- 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.
- The Louisiana State Board of Nursing (LSBN) must receive evidence of certification/recertification **directly** from the national nursing certification organization (approved by LSBN) in your APRN role and population focus. Reinstatement will be delayed until proof of national APRN certification has been received by LSBN from your national organization.

NOTE – If the APRN is applying for reinstatement of an advanced practice role and population focus where national certification was **not** available at the time original Louisiana licensure was issued, the applicant shall submit the following documentation for **each year** of inactive (or lapsed) status to demonstrate commensurate requirements:

1. minimum of 300 hours of practice as a fully licensed or permitted APRN for each year your Louisiana license was inactive or lapsed in the advanced practice role and population focus (up to a maximum of 800 hours). You are not authorized to obtain these clinical hours in Louisiana without a temporary APRN permit. Provide a letter requesting the APRN permit along with your reinstatement application. For further information, please contact our APRN department at advancedpractice@lsbn.la.gov.

And

- 2a. a minimum of two (2) academic/college credit hours relevant to the specific advanced practice role and population focus the APRN is applying to reinstate for each year the Louisiana license was inactive/lapsed.
NOTE: an official transcript issued from the college/university must be submitted with application for this option.

Or

- 2b. a minimum of 30 contact/credit hours of accredited continuing education (CE) relevant to the specific advanced practice role and population focus the APRN is applying to reinstate for each year the Louisiana license was inactive/lapsed. CEs must be at the advanced level and accredited by an organization accepted by LSBN, see [VR-1 form](#) for list.

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

Prior to engaging in medical diagnosis and management as an Advanced Practice Registered Nurse (APRN), including writing orders and/or prescriptions, the APRN must obtain a letter of approval issued to the nurse by LSBN indicating approval for prescriptive authority (PA) privileges in the State of Louisiana in collaboration with licensed physician(s) or dentist(s). Click [here](#) for link to LSBN website to obtain separate application to apply for reinstatement of PA privileges. Rules regarding licensure reinstatement and APRN authorized practice may be located the LSBN website: www.lsbn.state.la.us. 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.lsbns.state.la.us

APPLICATION FOR REINSTATEMENT BY REGISTERED NURSE

LICENSE NO.	2015 YEAR
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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 2014.

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

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

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APPLICATION FOR REINSTATEMENT BY ADVANCED PRACTICE REGISTERED NURSE

		2015
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

____ CNM

____ CNS

____ CRNA

____ NP

2. Clinical Specialty

____ Acute Care NP

____ Adult Health CNS (formerly Medical – Surgical)

____ Adult NP

____ Adult Psychiatric & Mental Health CNS

____ Adult Psychiatric & Mental Health NP

____ Anesthetist (CRNA)

____ Child/Adolescent Psychiatric & Mental Health CNS

____ Clinical Nurse Specialist in Pediatric Nursing

____ CNS in Acute and Critical Care - Adult

____ CNS in Acute and Critical Care - Neonatal

____ CNS in Acute and Critical Care - Pediatric

____ Community Health CNS

____ Family NP

____ Family Psychiatric & Mental Health NP

____ Gerontological CNS

____ Gerontological NP

____ Home Health CNS

____ Maternal Child CNS

____ Midwife (CNM)

____ Neonatal NP

____ Oncology CNS

____ Pediatric NP

____ Women's Health Care NP

____ Other _____

3. Clinical Setting

____ College Student Health Clinic

____ Emergency Department

____ HIV/AIDS Clinic

____ Hospital

____ Medicine Clinic

____ Nursing Home

____ Outpatient Clinic

____ Pediatric Clinic

____ Physician's Office

____ Private Clinic

____ Rural Clinic

____ School Clinic

____ School of Nursing

____ Urban Clinic

____ Women's Health Clinic

____ Other _____

Section III. Advanced National Certification

If you are applying for reinstatement of an advanced practice role and population focus where national certification was **not** available at the time original Louisiana licensure was issued (grandfathered provision), leave **Section III** blank and proceed to **Section IV**. You must provide documentation to demonstrate commensurate practice and CE requirements (see [VR-1 form](#)). You are not authorized to obtain these clinical hours in Louisiana without a temporary APRN permit. Provide a letter requesting the APRN permit along with your reinstatement application. For further information, please contact our APRN department at advancedpractice@lsbn.la.gov.

If you are **nationally certified**, complete **Section III** below and contact your national organization to have proof of current certification sent **directly** to LSBN. If certified in more than one role and/or population foci, indicate advanced national certification as it applies to both primary and secondary clinical practice. **For example** - you are certified as a Family Nurse Practitioner (NP) through ANCC and also a Women’s Health Care NP through NCC, but your **primary** employment is as a FNP, then your primary certification would be ANCC and secondary certification would be NCC. **NOTE:** proof of current national certification will be required for each role and population foci you previously held Louisiana licensure and wish to reinstate.

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

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

2. Advanced Practice Certified Role and Population Foci (Select only one in each column)

Primary	Secondary	
<input type="checkbox"/>	<input type="checkbox"/>	Acute Care Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Adult-Gerontological Acute Care Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Adult-Gerontological Primary Care Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Adult Health Clinical Specialist (formerly known as ‘Medical – Surgical Nursing CNS’)
<input type="checkbox"/>	<input type="checkbox"/>	Adult Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Adult Psychiatric and Mental Health Nursing Clinical Specialist
<input type="checkbox"/>	<input type="checkbox"/>	Adult Psychiatric and Mental Health Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Certified Nurse Midwife
<input type="checkbox"/>	<input type="checkbox"/>	Child and Adolescent Psychiatric and Mental Health Nursing Clinical Specialist
<input type="checkbox"/>	<input type="checkbox"/>	Clinical Nurse Specialist in Acute and Critical Care - Adult
<input type="checkbox"/>	<input type="checkbox"/>	Clinical Nurse Specialist in Acute and Critical Care - Neonatal
<input type="checkbox"/>	<input type="checkbox"/>	Clinical Nurse Specialist in Acute and Critical Care - Pediatric
<input type="checkbox"/>	<input type="checkbox"/>	Clinical Nurse Specialist in Pediatric Nursing
<input type="checkbox"/>	<input type="checkbox"/>	Community Health Nursing Clinical Specialist
<input type="checkbox"/>	<input type="checkbox"/>	Family Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Family Psychiatric and Mental Health Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Gerontological Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Home Health Clinical Specialist
<input type="checkbox"/>	<input type="checkbox"/>	Maternal Child Clinical Specialist
<input type="checkbox"/>	<input type="checkbox"/>	Nurse Anesthetist
<input type="checkbox"/>	<input type="checkbox"/>	Neonatal Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Oncology Clinical Nurse Specialist
<input type="checkbox"/>	<input type="checkbox"/>	Pediatric Nurse Practitioner
<input type="checkbox"/>	<input type="checkbox"/>	Women’s Health Care Nurse Practitioner

3. Certification expiration date: _____ **LSBN must receive evidence directly from certifying body**

Section IV. Practice Verification

Check one (1) of the following:

_____ I attest that I **have not practiced** as an APRN in Louisiana during the period that my license in the role and population focus applied herein for reinstatement was inactive/retired/delinquent; **OR**

_____ I attest that I **have practiced** as an APRN in Louisiana during the period that my license in the role and population focus applied herein for reinstatement was inactive/retired/delinquent. (*Submit 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 licensure 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: _____ Hire/Start Date (month/day/year) To: _____ Provide last day nurse worked: (month/day/year)

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 This Form

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

EMPLOYER/COMPANY NAME: _____

PERSON COMPLETING FORM: _____

EMAIL ADDRESS: _____

MAILING ADDRESS: _____

PHONE NUMBER (with extension): _____

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 blank FBI cards, LSBN board staff can mail you a set of 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 of the form, 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 law enforcement agency utilizes an electronic scan system ('LiveScan'), request they scan both hands for your fingerprints and print the first (1st) FBI card, then scan your hands again to print your fingerprints on the second (2nd) FBI card.
 - The following suggestions may improve the quality of your fingerprints to ensure LSBN receives the results of your CBC 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 opt to have their fingerprints scanned in person at the LSBN office ('LiveScan') by board staff instead of submitting paper FBI cards. 'LiveScan' fingerprinting must be completed before 3:00 pm central standard time (CST). The LSBN office opens at 8:30 am (CST), but closed for all state and federal holidays. Please try to arrive at the LSBN office by midday to allow sufficient time for processing if using the 'LiveScan' CBC option. The nurse must be able to submit their application (already completed & notarized) and fee(s) to LSBN staff when he/she arrives for 'LiveScan' fingerprinting.
- 3) **Fees due LSBN for CBC:**
 - \$40.75 – Payable to Louisiana State Board of Nursing (LSBN) if paper FBI fingerprint cards are submitted

- OR -

 - \$50.75 – 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 along 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**)

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):

- \$40.75 – Payable to Louisiana State Board of Nursing (LSBN) if paper FBI fingerprint cards are submitted
- **OR** -
- \$50.75 – 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

CITY STATE

70810

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, FBI and/or international files (if applicable) which may confirm or deny my eligibility with the facility or agency named above.

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

CITY

LA

STATE

70810

ZIP CODE

Provide/print 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

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 of blank FBI cards. Check the appropriate box, complete the form below (please PRINT) 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: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____

Work Phone Number (include extension): _____

Cell Phone Number: _____

E-mail Address: _____

NOTE: *If applying for initial Louisiana licensure, do not submit your application until you have received and completed the FBI fingerprint cards. Your full CBC packet must accompany your application.* If applying for license reinstatement, refer to instructions and application to determine if a CBC packet is required to accompany your application.