

APPLICATION FOR LICENSURE BY RE- EXAMINATION
BOARD OF NURSING



REGISTERED NURSE * LICENSED PRACTICAL NURSE

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514. If you have any questions, call HPLA Customer Service at 1-877-672-2174 Monday through Friday, 8:30 AM to 4:30 PM EST.

Please Note: Please refer to application instructions before completing this form.

SECTION 1A. LICENSURE TYPE & FEES

Please check one: LPN RN

Licensure by Re-Examination **\$85.00**

CRIMINAL BACKGROUND CHECK: For payment and to schedule an appointment (Call **1-877-783-4787** or www.L1enrollment.com)
All applicants are required to undergo a Criminal Background Check

LICENSURE EXPIRATION: All licenses expire **June 30th**
RNs even numbered year
LPNs odd numbered year

Make check or money order payable to: DC Treasurer

SECTION 2A. APPLICANT INFORMATION

Note: LEGAL NAME: *(Do not use any initials unless they are a part of your name)*

FIRST NAME MI LAST NAME (SUFFIX: Jr., Sr. etc.)

Name of Nursing School Attended: _____ Country: _____ Graduation Date: _____

DEGREE(S): AA DIPLOMA BSN MSN OTHER DEGREE _____

____/____/____
Date of Birth

____ - ____ - ____
Social Security Number *

GENDER: MALE FEMALE

***All Applicants must provide a Social Security Number. If you are a foreign graduate and do not have a SSN or are waiting for one to be issued, you must complete the SSN affidavit form and submit it with your application. Your license will not be renewed without a valid SSN. You can download the affidavit form by clicking [here](http://doh.dc.gov/service/health-professionals) or printing a copy at <http://doh.dc.gov/service/health-professionals>**

SECTION 2B. OTHER NAMES USED: (Please print clearly)

Enter your legal name exactly as it should appear on the license. If your name on this application is different from the name on your supporting documentation provide a copy of a legal name change document. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders and spouse's death certificate.

FIRST NAME MI LAST NAME (SUFFIX: Jr., Sr. etc.)

FIRST NAME MI LAST NAME (SUFFIX: Jr., Sr. etc.)

Place of Birth : State/Providence/Territory

Country if not USA

SECTION 2C: RACE & ETHNICITY DESIGNATION:

LANGUAGE(S) SPOKEN:

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION
APPLICATION FOR LICENSURE BY RE-EXAMINATION

SECTION 4. SUPPORTING DOCUMENTS REQUIRED

Your application along with all required supporting documents must be mailed in the same package to the Board office. Please mail in a 9X12 envelope and do not staple or fold application.

Please indicate the supporting documents you have included with this package. Keep a photocopy.

If not provided previously submit an official transcript from the applicant's school of nursing, must accompany the application in a sealed envelope. Or

Applicant will not be licensed until the official transcript is received indicating date the degree was conferred or date of graduation.

NCLEX-RN RE-EXAMINATION

- I have submitted an official transcript indicating the date the degree was conferred or date of graduation.
- I have re-registered with PearsonVue to retake NCLEX-RN and paid application fee of \$200.
- I completed my Registered Nursing program less than three (3) years ago.
If No, you are required to complete an additional education program leading to a degree as a registered nursing.

NCLEX-PN RE-EXAMINATION

- I have submitted an official transcript indicating the date the degree was conferred or date of graduation.
- I have re-registered with PearsonVue to retake NCLEX-PN and paid application fee of \$200.
- I completed my Practical Nursing program less than one (1) year ago.
If you answered "no" to this question attach proof of completion of a NCLEX review course

If you are requesting special accommodations to sit for NCLEX, provide the following information:

1. Identify the accommodations being requested
2. Submit a letter from the appropriate health professional which confirms the disability, and provides information describing the accommodations required
3. Submit a letter from your education program, indicating the modifications granted by the program

If you answered "Yes" to any of the questions in Section 5; if you have not done so already, provide a detailed explanation on a separate sheet of paper. Submit copies of relevant court reports, personnel actions, actions taken against your license or other relevant documents.

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SECTION 5. SCREENING QUESTIONS Applicants must answer all of the following questions		
<p style="text-align: center;"><u>Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement</u></p> <p>Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).</p> <p>PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be issued a license if you have failed to file your District tax returns.</p> <p>IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.</p> <p>As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:</p> <ol style="list-style-type: none"> 1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985); 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994); 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985); 4. Past due taxes; 5. Past due District of Columbia Water and Sewer Authority service fees; or 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)? 		
A	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession? YES NO <input type="checkbox"/> <input type="checkbox"/>	
B	Do you have a mental condition that currently impairs your ability to practice your profession? YES NO <input type="checkbox"/> <input type="checkbox"/>	
C	Have you ever been convicted or arrested for a crime or misdemeanor (other than a minor traffic violation)? YES NO <input type="checkbox"/> <input type="checkbox"/>	
D	Have you been terminated from or resigned from a clinical or professional training program due to a practice issue? YES NO <input type="checkbox"/> <input type="checkbox"/>	
E	Please answer with respect to DC or any other jurisdiction/state: (1) Have you withdrawn an application to practice your profession or voluntarily surrendered a license after formal charges have been filed against you or while under investigation? (2) Has any authority or peer review board taken adverse action against your license or privileges or informed you of any pending charges not previously reported to this Board? (3) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board? (5) Have you voluntarily surrendered your license? (6) Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility? YES NO <input type="checkbox"/> <input type="checkbox"/>	
F	Have you been party to a malpractice action or had a malpractice action brought against you? YES NO <input type="checkbox"/> <input type="checkbox"/>	
SECTION 6. LICENSEE AFFIDAVIT		
<p><i>I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.</i></p>		
_____ LICENSEE SIGNATURE	_____ PRINT NAME	_____ DATE
<p>*PLEASE NOTE: PRINT AND MAIL ORIGINAL APPLICATION TO THE BOARD OF NURSING AND RETAIN A COPY FOR YOUR FILES.</p>		

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.