APPLICATION FOR RN REINSTATEMENT
APPN INITIAL LICENSE

Use this application if:

The RN license is lapsed

An APPN license has never been issued previously

An Application packet for Prescriptive and Dispensing Authorization for Prescriptive Authority is also attached – Complete this application if you plan to prescribe legend drugs in the State of Idaho.

Criminal Background checks – All applicants are required to submit to a fingerprint-based criminal background check by the Idaho Central Criminal Database and Federal Bureau of Investigation criminal history database. Cards are available from the Board office.

Total Fees to be submitted:	**RN Reinstatement Fee**	**$125.00**
	Temporary License (if needed)	**$ 25.00**
	Fingerprint Processing Fee	**$ 30.00**
	APPN Application Fee	**$ 90.00**
	Prescriptive Authorization (if needed)	**$ 50.00**

APPLICATION INSTRUCTIONS FOR REINSTATEMENT OF RN LICENSURE AND ADVANCED PRACTICE PROFESSIONAL NURSE INITIAL LICENSURE

This application may be used for advanced practice professional nurse initial licensure (CNM, CNS, NP, RNA) and by professional nurses (RNs) who have a lapsed license to practice as a professional nurse (RN) in Idaho:

- *If you are applying for APPN licensure and are not currently licensed to practice in Idaho as a professional nurse (RN), you must apply for reinstatement of your professional nurse license **and** initial advanced practice professional nurse licensure and pay both licensure fees.*
- Temporary licensure. *Idaho has a mandatory nurse licensure law requiring nurses to be licensed to practice in Idaho at the time of employment. A temporary license may be issued for an interim period of ninety (90) days while the application for renewable licensure is being processed. Instructions for temporary licensure are included.*

The following must be on file with the Board of Nursing to determine your eligibility for licensure in Idaho. (All documents become the property of the Board and may be destroyed, without further notification, if the application is not completed within one year.) Documents requiring notarization may NOT be received by FAX.

The following items are required for all applications:

1. **APPLICATION FORM:** Only application forms provided by the Board, completed in ink and notarized will be accepted. Photocopies or Faxed copies of application forms will not be accepted.
   1) If all information requested is not supplied, provide an explanation for the omission.
   2) Sign the affidavit with your usual signature and have it notarized.
   3) Attach a 2 x 2 identification photograph, taken within the last year. Electronically scanned photos are not acceptable; features must be clearly identifiable. Black & white or color photos are acceptable.
   4) Complete page 3 indicating your advanced practice education and certification information.

2. **FEE.** Enclose the appropriate fee for all categories of licensure for which you are applying (personal checks are accepted):

Licensed Professional Nurse (RN) – Reinstatement	--	$125.00
Licensed Professional Nurse (RN) - Temporary License Fee	--	$25.00
Advanced Practice Professional Nurse (CNM, CNS, NP, RNA)	--	$90.00
APPN Temporary License	–	No Fee

3. **CENSUS QUESTIONNAIRE.** Complete the enclosed Census Questionnaire and return with your completed application. (Please leave the box requesting your license number blank.)

4. **EMPLOYMENT INFORMATION.** A satisfactory nursing employment reference from the three-year period immediately preceding the application is required **for professional nurse reinstatement**. The employment reference may be faxed to this office (208/334-3262) or mailed directly to the Board of Nursing from the employer. References will not be accepted from the applicant. *If you have not been employed in nursing within the last three years, do not complete the reference form. You may be required to obtain a conditional temporary license in order to update your nursing knowledge to qualify for Idaho licensure*.

5. **AFFIDAVIT:** The affidavit on page 2 of the application must be completed and notarized in order for your application to be valid.

6. **DECLARATION OF STATE OF RESIDENCE.** Complete the enclosed form attesting that your primary state is Idaho or another non-compact state.

7. **OFFICIAL TRANSCRIPT:** Request an OFFICIAL TRANSCRIPT indicating program completion from the advanced practice professional nursing program, to be mailed directly to the Board of Nursing office.

8. **FINGERPRINT CARD**. Complete the required Fingerprint card and submit to the Board for processing. Only cards from the Board office are acceptable **fee for processing - $30.00.**

9. **ADVANCED PRACTICE NATIONAL CERTIFICATION.** Indicate the name of the certifying organization for your category. List the date of original certification and submit a copy of your current certificate from a national organization. Nurse Practitioners NOT certified by a national organization and **approved previously to practice in Idaho prior to July 1, 1998**, shall be exempt from submitting evidence of certification. If your certification has lapsed, see instructions under "Temporary License" on reverse side of these instructions.

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TEMPORARY LICENSURE FOR ADVANCED PRACTICE PROFESSIONAL NURSE APPLICANTS

Advanced practice professional nurse applicants (CNM, CNS, NP, RNA) applying for APPN temporary licensure, who are currently authorized to practice in Idaho under a renewable professional (RN) license must submit the completed application form and the "Affidavit Attesting to Validity of Copy", attached to one of the following documents:

1) If you hold national certification, submit a copy of your current certificate showing the expiration date; or
2) If you have not yet taken the certification examination, submit a copy of the document which verifies acceptance to take the examination. In addition, evidence of completion of an Advanced Practice Professional Nursing education program is required. If a final transcript is not yet available, submission of one of the following documents is acceptable:
    a. Correspondence received directly (by FAX or mail) from the director of the educational program attesting to completion of all graduation requirements; or
    b. Notarized copy of diploma.
3) If your national certification has lapsed, submit a copy of your lapsed certificate. The Board will consider issuance of a conditional temporary license in order for you to meet specified practice requirements under supervision for re-entry into advanced practice professional nursing.

PLEASE BE ADVISED: Licensed professional nurses and advanced practice professional nurses must renew their license(s) by August 31st of every odd-numbered year. A nurse who applies for licensure on or after March 1st of the year in which the license would ordinarily be renewed, will be issued a license valid until the next renewal period.

APPN Initial – Lapsed RN 3/2009

IDAHO BOARD OF NURSING - PO BOX 83720 - BOISE, ID 83720-0061
(208) 334-3110
APPLICATION FOR LICENSURE

For Office Use Only

License #_____
APPN #_____
Receipt#_____
Amount _____
Approval
Temp_____
Licensure_____

Check **all** categories for which application is being made:

- ☐ **Licensed Practical Nurse (LPN)**
  - ○ Licensure by Endorsement
  - ○ Licensure by Reinstatement
- ☐ **Licensed Professional Nurse (RN)**
  - ○ Licensure by Endorsement
  - ○ Licensure by Reinstatement
- ☐ **Advanced Practice Professional Nurse**
  - ○ Certified Nurse-Midwife
  - ○ Clinical Nurse Specialist
  - ○ Nurse Practitioner
  - ○ Registered Nurse Anesthetist
- ☐ **Temporary Licensure**

AFFIX A 2" X 2"
PHOTOGRAPH
HEAD AND SHOULDERS ONLY
Taken within the Year
DO NOT STAPLE

Date of photo_____

Name_____
Last First Middle Maiden
Other names used previously_____

Mailing Address_____
City State Zip Code
Telephone - Home: ( )_____Work: ( ) _____ S.S. No. _____

Birthplace_____Birth Date_____
(City & State) (Mo/Day/Year)

BASIC RN/LPN EDUCATION

Name of Practical Nursing (LPN) Education Program _____

Location_____

Month/Year Graduated_____Type of Degree/Credential_____

Name of Professional Nursing (RN) Education Program_____

Location_____

Month/Year Graduated_____Type of Degree/Credential_____

LICENSURE

1. Have you ever taken the State Board Test Pool Examination (SBTPE) or National Council Licensure Examination (NCLEX) in any state of the United States? ☐ Yes ☐ No ☐ RN ☐ PN
2. Have you ever been licensed or made application for licensure as an RN/LPN/APPN in Idaho prior to this date? ☐ Yes ☐ No If previous Idaho licensure, indicate year and name used_____
3. State and year of original RN/LPN licensure_____ License No._____
4. List all states in which you are or have ever been licensed_____
   _____

YOU MAY NOT PRACTICE NURSING IN IDAHO AS DEFINED IN THE NURSING PRACTICE ACT, IDAHO CODE, SECTION 54-1401 THROUGH 54-1417, UNTIL YOU HAVE FILED AN APPLICATION AND RECEIVED A TEMPORARY OR RENEWABLE LICENSE.

EMPLOYMENT INFORMATION

LIST LAST THREE (3) YEARS OF NURSING EMPLOYMENT: **(Additional information may be listed on a separate sheet.)**

Name & Complete Address of Employer	Position	Employment From	Employment To

If you have not been employed in nursing within the last three years, or if there are gaps in employment, indicate your **last year of nursing employment** and explain the reason. (Supervised practice and a content update may be required if you have not engaged in nursing practice during the last three years.)_____

_____

IT IS THE DUTY OF EACH APPLICANT TO MAKE INQUIRY OF THE INDIVIDUAL LICENSING BOARDS REGARDING THE STATUS OF LICENSURE IN THAT STATE BEFORE RESPONDING TO THE QUESTIONS BELOW. Ignorance of license status or disciplinary information will not constitute an excuse for incorrect information. In addition, failure to disclose all licenses may result in denial of your application or other appropriate action.

SCREENING QUESTIONS

PLEASE ANSWER ALL QUESTIONS (For all "yes" answers, attach a complete explanation including dates, circumstances and supporting documents if necessary.)

1.	Has your nursing license ever been disciplined in any state (e.g., revoked, suspended, placed on probation, formally reprimanded, or otherwise encumbered)?		☐Yes	☐No
2.	Is any action pending against your nursing license in any state?		☐Yes	☐No
3.	Have you ever had approval to practice in an advanced role denied, limited, suspended, revoked or otherwise disciplined?	☐NA	☐Yes	☐No
4.	Have you ever had an application for nursing license denied?		☐Yes	☐No
5.	Have you ever been denied admission to take a nursing examination by any state?		☐Yes	☐No
6.	Do you have, or have you been diagnosed as having, or have you been treated for having a physical or mental condition, including drug or alcohol addiction during the past five (5) years, which may impair your ability to practice nursing with reasonable skill and safety?		☐Yes	☐No
7.	If yes, do you require special accommodations in order to practice?	☐NA	☐Yes	☐No
8.	Do you currently have any felony or misdemeanor charges pending against you in any jurisdiction?		☐Yes	☐No
9.	Have you ever pled guilty, entered a plea of nolo contendre, been convicted of, or received a withheld judgment for a misdemeanor or felony in any jurisdiction?		☐Yes	☐No

THE AFFIDAVIT BELOW MUST BE COMPLETED IN ORDER FOR YOUR APPLICATION TO BE VALID.

A F F I D A V I T

State of _____)
) s.s.
County of _____)

I,_____being duly sworn, declare that I understand the instructions and terms as set forth in this application form, that I am the person referred to in the foregoing application and this affidavit, and that I have personally completed this form, and that the information given in this application is true, correct and complete. I declare that I have no mental or physical disabilities (except as otherwise noted above) that presently interfere with my ability to competently and safely practice nursing and that I have read and understand this affidavit.

_____
Signature of Applicant

On this _____ day of _____, in the year of _____before me _____, notary public, personally appeared _____known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

_____

WITNESS my hand and official seal. My Commission expires_____

 Applicant Name_____

The following must be completed by Advanced Practice Professional Nurses applying for licensure in the categories of Certified Nurse-Midwife, Clinical Nurse Specialist, Nurse Practitioner or Registered Nurse Anesthetist.

ADVANCED PRACTICE PROFESSIONAL NURSE EDUCATION *

*Official Transcript is required and must be mailed by the granting institution directly to the Board of Nursing.

Please ☑ the category for which you are applying for licensure:

☐**Certified Nurse-Midwife**: Name of Nurse-Midwifery Program:_____

Location of Program:_____

Dates Attended:_____ Degree/Credential_____

☐**Clinical Nurse Specialist:** Name of Graduate Nursing Program:_____

Location of Program:_____

Dates Attended:_____ Degree/Credential_____

☐**Nurse Practitioner:** Name of Nurse Practitioner Program:_____

Location of Program:_____

Dates Attended:_____ Degree/Credential_____

☐**Registered Nurse Anesthetist:** Name of Nurse Anesthesia Program:_____

Location of Program:_____

Dates Attended:_____ Degree/Credential_____

ADVANCED PRACTICE PROFESSIONAL NURSE CERTIFICATION

APPN Certification:

Name of certifying organization:_____

Date of original certification:_____

If not yet certified, date scheduled for examination_____

A notarized copy of your current certificate, or a document which verifies acceptance to take the examination must be enclosed.

3/2009

NURSING EMPLOYMENT REFERENCE FORM

LICENSURE APPLICANT:

1. If you have been employed as a nurse at some time within the last three years for a minimum of 30 days, complete the release information at the top of this form and send to a registered nurse/supervisor from your current or most recent place of employment for completion of the bottom section. The form must be returned ***directly*** to the Board by the nursing employer**.**
2. If you graduated from a nursing education program *less than one year ago **AND** you have **not** been employed as a nurse for a minimum of 30 days*, complete the release information at the top of this form and send to a faculty member at your nursing education program for completion of the bottom section. The form must be returned ***directly*** to the Board office by the faculty.

TO: _____ _____

PLACE OF EMPLOYMENT (OR NURSING SCHOOL) SUPERVISOR (OR FACULTY CHAIR)

I,_____, Social Security # _____ have applied to the
(Name of Nurse Applicant)

the Idaho Board of Nursing for licensure as an _____ nurse. I stated on my licensure application
(RN/LPN/APPN)

that I was **employed/enrolled** at your institution as a _____ for the following
(circle one) (RN, LPN, RNA, NP, CNM, CNS, other)

period: _____ to _____. I hereby authorize you to release to the Idaho Board of Nursing for licensure purposes, the information requested below.

_____ _____

DATE SIGNATURE OF APPLICANT

ATTENTION: THIS FORM WILL NOT BE ACCEPTED DIRECTLY FROM THE APPLICANT.

NURSING EMPLOYER (OR FACULTY MEMBER):

The above named person has applied for licensure as a nurse in the State of Idaho and has given your name as a reference. Please furnish the information requested below and return the completed form by mail or FAX to:

IDAHO BOARD OF NURSING, P.O. BOX 83720, BOISE, ID 83720-0061 - FAX: (208) 334-3262

(If returning this form by FAX, please do not follow up with a hard copy.)

1. The applicant was **employed/enrolled** from _____ to _____.
(circle one)

as a(n): ☐ RN ☐ CNM ☐ NP
☐ LPN ☐ CNS ☐ RNA
☐ OTHER* _____

If OTHER is checked, please specify job title in the blank and list job duties on the reverse side of this form.

2. GENERAL HISTORY: ** Met performance requirements ☐
Performance **NOT** satisfactory ☐ ***(If NOT satisfactory, please explain on reverse side.)***

** If unable to release this information, please initial here_____, sign and return this form.

_____ _____

DATE SIGNATURE AND TITLE

EMPLOYER OR SCHOOL: _____
MAILING ADDRESS: _____
_____
PHONE and FAX NUMBERS: _____

3/09

IDAHO BOARD OF NURSING
Professional Nurse (RN)
CENSUS QUESTIONNAIRE

For Office Use Only

Cert #_____
Rec't #_____ Amt_____
Date Issued_____
☐ Reinstatement
☐ Endorsement

Please Print
NAME :_____

ADDRESS :_____

CITY & STATE :_____
Zip Code

Idaho License No.	Birth Date	Social Security No.	Gender* (Optional)	County Name	
	/ /	- -		Residence:	Employment:

Ethnicity* (Optional) ☐ Caucasian(1) ☐ African American/Black(2) ☐ Hispanic(3) ☐ Am. Indian/Alaska Native(4)
☐ Asian/Pacific Islander(5) ☐ Multi-Racial(6) ☐ Other(99)_____

(*Voluntary disclosure information – response optional)
Please choose only one answer for each question, write the appropriate number in the box to the left.

EMPLOYMENT STATUS
1. Employed in nursing full-time
2. Employed in nursing part-time
3. Employed outside nursing
4. Not Employed/Seeking Employment
5. Not Employed/Student
6. Not Employed/Not Seeking
7. Volunteer
8. Emeritus
9. Retired

PRIMARY EMPLOYER
Employer_____ Address_____

PRIMARY EMPLOYMENT
1. Hospital
2. Nursing Home
3. Home Health/Hospice
4. Public Health
5. Occupational Health
6. Medical Office/Clinic
7. Assisted Living
8. Nursing Education
9. Insurance Company
10. Jail/Prison
11. School Health
12. Outpatient Facility
99. Other (specify)_____

TYPE OF POSITION
1. Staff or General Duty
2. Case Manager/Discharge Planner
3. Administrator/Supervisor
4. Educator
5. Advanced Practice (not RN Specialty)
6. Quality Assurance/Outcomes Management
7. Consultant/Researcher
8. Charge/Lead Nurse/ Team Leader
99. Other (specify)_____

MAJOR CLINICAL AREA
1. Geriatric
2. Gynecologic/Obstetric
3. Medical/Surgical
4. Pediatric
5. Psychiatric/Mental Health
6. Emergency
7. Community/Public Health
8. Rehabilitation/Restorative
99. Other (specify)_____

BASIC EDUCATION
1. Diploma
2. Associate Degree
3. Baccalaureate Degree or Higher
4. Other (specify)_____

HIGHEST DEGREE
1. Diploma/RN
2. Associate Degree/RN
3. Baccalaureate Degree/RN
4. Baccalaureate Degree in Other Field (specify)_____
5. Masters in Nursing
6. Masters in Other Field (specify)_____
7. Doctorate in Nursing
8. Doctorate in Other Field (specify)_____
9. PN Certificate/Diploma
10. PN Associate Degree
99. Other (specify)_____

Year Advanced Degree was Granted_____

I am currently taking courses toward an additional/advanced degree in nursing? ☐ Yes ☐ No
I intend to leave/retire from the practice of nursing in the next five years? ☐ Yes ☐ No
States other than Idaho in which I am practicing:_____

Information provided is for statistical purposes only.

DECLARATION OF PRIMARY STATE OF RESIDENCE
NURSING LICENSURE INTERSTATE COMPACT

Dear Applicant for Licensure by Interstate Endorsement or Reinstatement:

On July 1, 2001, Idaho became a member of the Nurse Licensure Compact. Other states include Arizona, Arkansas, Colorado, Delaware, 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, and Wisconsin.

Under terms of the Nurse Licensure Compact, nurses may hold a license to practice issued by their state of residence, if that state is a Compact state, and are granted the privilege to practice in other Compact states without holding separate licenses in those other states. If you reside in a Compact state, you may hold a Compact state license only in your declared state of residence; you may not be licensed in any other Compact state. If you reside in a state that is not a member of the Compact and you apply for licensure to practice in any Compact state, you will be issued a license by the individual Compact state that will be designated as valid for practice only in that state.

If you are applying for licensure in Idaho and indicating a mailing address in another Compact state, it is imperative that you inform the Idaho Board as to which scenario best suits your particular situation, to ensure that appropriate procedures are followed in issuing your Idaho license or in directing you to contact the appropriate state(s) to apply for and receive a license.

Please note, if you are in the process of moving to Idaho and declaring Idaho as your state of residence, you must provide the Idaho Board with an Idaho address within 30 days of relocating to this state. Upon notice of address change, licenses held in any other Compact state will become invalid.

More information regarding the Nurse Licensure Compact is available on the National Council of State Boards of Nursing web site at http://www.ncsbn.org. If you have questions about your application, please contact the Board at (208) 334-3110 ext. 21.

----------Tear off and return----------

DECLARATION OF STATE OF RESIDENCE

Name_____

Address:_____

Primary state of residence is defined as "the state of a person's declared fixed permanent and principal home for legal purposes; domicile. Documentation of state of residence includes a valid driver's license with a home address, voter registration card with a home address, and/or the state declared as the state of residency on the last federal tax return.

Based on the definition above, my primary state of residence is_____
I am currently practicing nursing (including telenursing) in the following states:

_____

_____

Check one:

- ☐ I am declaring Idaho as my state of residence, even though my mailing address is in another Compact state.
- ☐ I am declaring Idaho as my state of residence; my mailing address is listed below.
- ☐ I am practicing in Idaho, but am declaring another Compact state as my state of residence.
- ☐ I am practicing in Idaho, but am declaring a Non-Compact state _____ as my state of residence.
- ☐ I am a member of the armed forces and am declaring Idaho as my state of residence.
- ☐ I am in the process of moving to Idaho, but do not yet have an Idaho mailing address.

Signature_____ Date_____
Address:_____

AFFIDAVIT ATTESTING TO VALIDITY OF COPY

I hereby certify that the attached is a direct photocopy of:
Please ☒ appropriate box (es).

- ❒ The certificate which shows proof of current licensure as a licensed professional nurse (RN)
- ❒ The certificate which shows advanced practice professional nurse national certification
- ❒ The document which verifies acceptance to take the certification examination
- ❒ The diploma from my Advanced Practice Professional Nurse educational program

Total number of documents_____ _____
Signature of Applicant

On this _____ day of _____, in the year of _____, before me _____, a notary public, personally appeared _____, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

(Notary Seal) _____
Notary Public

_____
My Commission Expires

----------Tear Here----------

The following items must be submitted when you file your application for **RN & APPN** licensure:

- ☐ Completed, notarized application – pages 1, 2 **and** 3.
- ☐ Fees – for Advanced Practice Professional Nurse licensure and RN Reinstatement
- ☐ Declaration Form
- ☐ Affidavit attesting to the Validity of Copies – attach a copy of your APPN Certification card and current RN License
- ☐ Fingerprint Card

Be sure that you have requested that an **OFFICIAL TRANSCRIPT** of your advanced practice professional nursing program be submitted directly to the Board office.

The Idaho Legislature recognizes the importance of health care to all Idahoans and has provided for accessibility to provider profile information on specified licensed professionals through the passage of Idaho Code 54-4503. The database, known as IDACARE, will enable the public to make a more informed decision about their health care provider.

The Patient Freedom of Information Act requires that Advanced Practice Professional Nurses (Certified Nurse-Midwives, Clinical Nurse Specialists, Nurse Practitioners, and Registered Nurse Anesthetists) provide information regarding their educational background, work history, disclosure of any final board disciplinary actions, criminal convictions, malpractice history, and other pertinent information as required by law. Information is updated at the time the license is renewed.

Following the granting of licensure by this Board, you will be provided with the web address, login information and password to access the on-line profile form for completion.

For questions concerning IDACARE, contact the Board office at (208) 334-3110 ext. 21. You may also access pertinent sections of the Idaho Code by linking from our home page at: www.ibn.idaho.gov or accessing IDACARE at: https://idacare.gov/secure/update/userentry.cfm