

FOR OFFICE USE ONLY
Receipt #
ID#
Issue Date
License #

Rhode Island Board of Nurse Registration and Nursing Education

Room 103 3 Capitol Hill Providence, RI 02908-5097

Instuctions and License Application for APRN: Select 1 Population Focus

CNS Adult/gerontology

the lifespan

CNS Neonatal

CNS Family/individual across

CNP Adult/gerontology

the lifespan

CNP Neonatal

Phone: (401) 222-5700

CNP Family/individual across

CNP Pediatric CNP Psychiatric/mental health CNP Women's health/gender relate	CNS Pediatric CNS Psychiatric/mental health CNS Women's health/gender related			
CRNA Family/individual across the I	espan espan			
MILITARY STATUS ELIGIBILITY (Documentation Required) see next page for instructions Please check ONE of the following criteria for expedited application: I am in active military duty or a reservist I am a military veteran with honorable discharge I am the spouse of someone in active military duty or the spouse of a reservist				
Applicant - Print Name				
LAST NAME	FIRST NAME MI			
Do Not Hand Deliver - Application Must Be Mailed				

TTY/TDD: (800) 745-5555

Revised 11/15/2024 jcp

Fax: (401) 222-6683

Licensure Requirements

	Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.				
	Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amoun \$145.00 and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.				
	Official transcript from the educational program, submitted by the college/school/university, directly to the Board. Transcript must include date of completion, graduation date, degree and evidence of Advanced Pathophysiology, Advanced Health Assessment and Advanced Pharmacology.				
	Copy of Active RN license in Rhode Island or Active multistate license in your state of primary residence.				
	Letter of APRN certification from professional certifying organization				
	National Criminal Background check supported by fingerprints. This report MUST be sent directly from the Department of Attorney General (AG) to the RI Board of Nursing. For information on this process please visit their website at http://www.riag.state.ri.us/homeboxes/BackgroundChecks.php or call 401-274-4400.				
	If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held an advanced practice nurse license. (Interstate Verification Form included in this application can be used for that purpose) Please visit the National Council of State Boards of Nursing website at: www.ncsbn.org to obtain contact information for all U.S. licensing authorities.				
	If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.				
Rhode	Island Controlled Substance Registration (CSR) - Application Fee - \$200.00				
	Completed Rhode Island Uniform Controlled Substances Act Registration Form (CSR) enclosed in this application to be used for that purpose.				
In order to dispense, prescribe, store, or order controlled substances, you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration. After you obtain your Rhode Island CSR you must apply for a federal DEA Number. That DEA number must be registered to a RI Business Address. An application for the federal DEA Number can be obtained by contacting DEA: DEA Phone Number (617) 557-2200. Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps					
Licens	sure Information				
	Please visit the RIDOH website at http://www.health.ri.gov/licenses to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.				
Licens	e Certificates				
	will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.				
I	I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00				



State of Rhode Island Board of Nursing Registration and Nursing Education

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens. 1. Name(s) Title (i.e., Mr., Mrs., Ms., Dr., etc.) This is the name that will be printed on your License/Permit/Certificate and reported First Name to those who inquire about your License/ Middle Name Permit/Certificate. Do not use nicknames, etc. Surname, (Last Name) Suffix (i.e., Jr., Sr., II, III) Maiden, if applicable Name(s) under which originally licensed in another state, if different from above (First, Middle, Last). "Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as 2. Social Security amended, I attest that I have filed all applicable tax returns and paid all Number U.S. Social Security Number taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State." 3. Gender Please select from the dropdown. 1 9 4. Date of Birth 5. Home 1st Line Address (Apartment/Suite/Room Number, etc.) **Address** It is your responsibility to notify the board of all Second Line Address (Number and Street) address changes. City Zip Code Country, If NOT U.S. Postal Code, If NOT U.S. Home Phone Home Fax Email Address (Format for email address is Username@domain e.g. applicant@isp.com) 6. Business **Address** Name of Business/Work Location (ONLY if it is **RELATED** to 1st Line Address (Department/Suite/Room Number, etc.) your license.) Second Line Address (Number and Street) It is your responsibility to notify the board of all address changes. City State Zip Code This address will appear on the De-Country, If NOT U.S Postal Code, If NOT U.S. partment of Health web site. **Business Phone Business Fax**

Applicant: Print your complete last name > 7. Preferred Please use my Home Address as my preferred mailing address Mailing **Address** Please use my Business Address as my preferred mailing address Please check ONE 8. Qualifying Type of School (University, College, Trade/Technical School etc.) **Education** Please list the name and information about Name of School the school that you attended which led Year Graduated: to your advanced practice license. 9. Certification Organization Granting Certification Please provide your Certification Information here 10. Original APRN Yes No Have you ever held, or do you currently hold, a license in another state? **State License** If the answer to this question is "yes", list the original state of licensure, license number, original issue date, and, if applicable, enter all other state abbreviation(s) of Please answer the licenses in Question 11 (below): question and list state(s), if applicable Original Issue Date Original Licensure State and License Number State License Number 11. Nursing State/Country: License Type (APRN) ` Status Licensure ☐ Active ☐ Inactive List all states or Inactive ☐ Active countries in which you are now, or ever have been licensed ☐ Active Inactive to practice as an APRN ☐ Active ☐ Inactive NOTE: ☐ Active Please indicate the ☐ Inactive current license type and status of each Active ☐ Inactive entry. Active Inactive ☐ Active Inactive ☐ Active Inactive

12. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending?

Abbreviation of State and Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance):

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Month

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Yes

Nο

13.	Disciplinary Questions Check either Yes or No for each question. NOTE: If you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter.	1. Are there any charges or investigations pending, in any state, against you? Yes No		
		2. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? Yes No		
		3. Have you ever had any disciplinary action(s) taken, or is any pending against your license to practice nursing, or any other licenses, registrations or certifications that you hold; or are any complaints pending in any state? Yes No		
		Note: If you answered "yes" to any of these questions you must submit a written explanation.sheet of paper.		
i a M h	I. Affidavit of Applicant Complete this section I,, being first duly sworn, depose and say that referred to in the foregoing application and supporting documents.			
	and sign. Make sure that you have completed all components accurately and completely.	I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Nurse Registration and Nursing Education any information which is material to my application for licensure		
		I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as nurse in the State of Rhode Island.		
		I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Nurse Registration and Nursing Education of any change in the answers to these questions after this application and this affidavit is signed.		
		Signature of Applicant Date of Signature (MM/DD/YY)		

Substitute forms are not acceptable - This form may be duplicated as needed.



Rhode Island Board of Nurse Registration and Nursing Education

Room 103, Three Capitol Hill Providence, RI 02908-5097 (401) 222-5700

INTERSTATE VERIFICATION FORM - ALL STATES OF LICENSURE

I am applying for a license to practice as an APRN in the State of Rhode Island. The Rhode Island Board of Nurse Registration and Nursing Education requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Nurse Registration and Nursing Education at the above address. Print/Type Full Name Signature Date Previous Names Used Social Security Number Date of Birth License Number Date Issued THIS SECTION TO BE COMPLETED BY THE NURSING BOARD Basis for Issuing License: □ APRN Licensed by: ☐ Endorsement ☐ Exam License Status: Original Date Issued: **Expiration Date:** ☐ Active ☐ Inactive □ Lapsed Questions: 1. Has this registered nurse ever been investigated by your Board? Yes □ No 2. Has this registered nurse incurred any disciplinary proceedings in your state, or is any action pending? Yes □ No 3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed ☐ Yes □ No on probation? 4. Do you know of any information that may discredit this person? ☐ Yes □ No If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.). Certification: Signature Date Type or Print Name Please Affix **Board Seal Here** Title Full Name of Licensing Board Please return directly to the Board at the above address. Thank you for your prompt cooperation.



Rhode Island Board of Nurse Registration and Nursing Education

Room 103, 3 Capitol Hill Providence, RI 02908-5097 (401) 222-5700

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniformed Controlled Substances Act Registration (CSR). I understand that there is an additional \$200.00 fee for this Registration and that the check or money order must be made out to the RI General Treasurer.

Print/Type Full Name		Rhode Island Business Name		rrent RI NPP/PCNS Li- nseNo.
Signature		Rhode Island Business Address	Bu	siness Telephone
Date			Bu	siness Fax
Complete this applica- tion for registration to prescribe controlled substances in the	The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site: www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm			
	Drug Schedule (Check all that apply)			
State of Rhode Island	Schedule II Sche	edule III Schedule	e IV	ScheduleV
A CSR is not required if there will be no controlled substances prescriptions pre-	A Copy of the DEA Registration must be provided to the Nursing Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*			
The CSR is renewed at the same time that the professional license is renewed.	All Applicants MUST answer the following: A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter			dmin-
NOTE: Read Important Infor- mation on the bottom of this application.	B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? If you answered "Yes" to question "A" or "B" attach an explanation to this form.			

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID". Licensed drug facilities and licensed practitioners with prescriptive privileges, cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: www.deadiversion.usdoj.gov./drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units maybe dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.



Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § <u>5-88-1</u> et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type:

II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. You do not need to complete the rest of this application – please skip to the signature line.

III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

VI. Criminal Background Check (a "BCI") (unless required in the initial license application) BCI completed from the RI Attorney General's Office.

VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date