# State of California
# Office of Administrative Law

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|---|---|
| **In re:**<br>**Board of Registered Nursing**<br><br>**Regulatory Action:**<br><br>**Title 16, California Code of Regulations**<br><br>**Adopt sections:**<br>**Amend sections: 1483**<br>**Repeal sections:** | **NOTICE OF APPROVAL OF CHANGES WITHOUT REGULATORY EFFECT**<br><br>**California Code of Regulations, Title 1, Section 100**<br><br>**OAL Matter Number: 2019-0319-04**<br><br>**OAL Matter Type: Nonsubstantive (N)** |

In this change without a regulatory effect, the Board amends its regulation to update the revision date of three application forms incorporated by reference, which are changed to reflect the new Governor, Gavin Newsom, on the letterhead of the forms.

OAL approves this change without regulatory effect as meeting the requirements of California Code of Regulations, title 1, section 100.

Date: April 24, 2019

Thanh Huynh
Senior Attorney

For: Holly Pearson
Acting Director

Original: Joseph Morris, Executive Officer
Copy: Dean Fairbanks

STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE LAW

# NONSUBSTANTIVE

## NOTICE PUBLICATION/REGULATIONS SUBMISSION (See instructions on reverse)

STD. 400 (REV. 01-2013)

For use by Secretary of State only

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
APR 24 2019
1:30 PM

| OAL FILE NUMBERS | NOTICE FILE NUMBER | REGULATORY ACTION NUMBER | EMERGENCY NUMBER |
|---|---|---|---|
| | Z- | 2019-0319-04N | |

For use by Office of Administrative Law (OAL) only

2019 MAR 19 P 4:02

OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY: Board of Registered Nursing

AGENCY FILE NUMBER (If any):

## A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

| 1. SUBJECT OF NOTICE | TITLE(S) | FIRST SECTION AFFECTED | 2. REQUESTED PUBLICATION DATE |
|---|---|---|---|
| | | | |

| 3. NOTICE TYPE | 4. AGENCY CONTACT PERSON | TELEPHONE NUMBER | FAX NUMBER (Optional) |
|---|---|---|---|
| ☐ Notice re Proposed Regulatory Action ☐ Other | | | |

| OAL USE ONLY | ACTION ON PROPOSED NOTICE | NOTICE REGISTER NUMBER | PUBLICATION DATE |
|---|---|---|---|
| | ☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn | | |

## B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): Advance Practice Registered Nurses (APRN) Applications Letterhead

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S):

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

| SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.) | ADOPT | AMEND | REPEAL |
|---|---|---|---|
| TITLE(S): 16 | | 1483 | |

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify) _____
- ☒ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)
N/A

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☐ Effective on filing with Secretary of State
- ☒ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

| 7. CONTACT PERSON | TELEPHONE NUMBER | FAX NUMBER (Optional) | E-MAIL ADDRESS (Optional) |
|---|---|---|---|
| Dean Fairbanks | (916) 574-7684 | (916) 574-7700 | dean.fairbanks@dca.ca.gov |

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: Joseph M Morris | DATE: 3/18/19

TYPED NAME AND TITLE OF SIGNATORY: Joseph Morris, Executive Officer, Board of Registered Nursing

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

APR 24 2019

Office of Administrative Law

**BOARD OF REGISTERED NURSING**

**Changes without Regulatory Effect**

**Language**

Proposed changes are designated by single underline and ~~strikeout~~.

**1483. Evaluation of Credentials.**

(a) An application for evaluation of a registered nurse's qualifications to be certified as a nurse practitioner shall be filed with the board by submitting the Application for Nurse Practitioner (NP) Certification (Rev. 03/~~2018~~2019), which is hereby incorporated by reference. A temporary Nurse Practitioner (NP) certificate shall be obtained by submitting the Application for Temporary Nurse Practitioner (NP) Certificate (Rev. 03/~~2018~~2019), which is hereby incorporated by reference. In order to furnish drugs or devices in California as a Nurse Practitioner, the certified nurse practitioner must be issued a Nurse Practitioner Furnishing Number by submitting the Nurse Practitioner Furnishing Number Application (Rev. 03/~~2018~~2019), which is hereby incorporated by reference, for approval. Submission of each application shall be accompanied by the fee prescribed in Section 1417 and such evidence, statements or documents as therein required by the board.

(b) The Application for Nurse Practitioner (NP) Certification, the Application for Temporary Nurse Practitioner (NP) Certificate and the Nurse Practitioner Furnishing Number Application shall include submission of the name of the graduate nurse practitioner education program or post-graduate nurse practitioner education program.

(c) The Application for Nurse Practitioner (NP) Certification shall include submission of an official sealed transcript with the date of graduation or post-graduate program completion, nurse practitioner category, credential conferred, and the specific courses taken to provide sufficient evidence the applicant has completed the required course work including the required number of supervised direct patient care clinical practice hours.

(d) A graduate from a board-approved nurse practitioner education program shall be considered a graduate of a nationally accredited program if the program held national nursing accreditation at the time the graduate completed the program. The program graduate is eligible to apply for nurse practitioner certification with the board regardless of the program's national nursing accreditation status at the time of submission of the application to the Board.

(e) The board shall notify the applicant in writing that the application is complete and accepted for filing or that the application is deficient and what specific information is required within 30 days from the receipt of an application. A decision on the evaluation of credentials shall be reached within 60 days from the filing of a completed application. The median, minimum, and maximum times for processing an application, from the receipt of the initial application to the final decision, shall be 42 days, 14 days, and one year, respectively, taking into account Section 1410.4(e) which provides for abandonment of incomplete applications after one year.

Note: Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2815 and 2835.5, Business and Professions Code.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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BOARD OF REGISTERED NURSING
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# APPLICATION FOR NURSE PRACTITIONER (NP) CERTIFICATION

APPLICATION FEE - $500.00

☐ MILITARY HONORABLE DISCHARGE - Check here if you served as an active duty member of the Armed Forces of the United States and were honorably discharged.

## PERSONAL DATA *(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number and Street | | |
| City | State / Country | Postal/Zip Code |
| HOME TELEPHONE NUMBER: ( ) | ALTERNATE TELEPHONE NUMBER: ( ) | E-MAIL ADDRESS: |
| DATE OF BIRTH: *(Month/Day/Year)* | U.S. SOCIAL SECURITY NUMBER OR INDIVIDUAL TAXPAYER ID NUMBER: | PREVIOUS NAMES: *(Including Maiden)* |
| MOTHER'S MAIDEN NAME: *(Last Name Only)* | | |

## RN LICENSURE/NURSE PRACTITIONER CERTIFICATION

California RN License Number: _____

Date Issued: _____

Expiration Date: _____

List ALL States Where You Hold/Held an RN License and Status:

List ALL States Where You Hold/Held a Nurse Practitioner License/Certificate and Status:

## RN EDUCATION

Name of Professional Registered Nursing Program

City State Country

TYPE OF PROGRAM:

- ☐ ASSOCIATE DEGREE
- ☐ DIPLOMA
- ☐ BACCALAUREATE DEGREE
- ☐ MASTERS DEGREE/NURSING

Entrance Date: _____

Graduation/Completion Date: _____

## NURSE PRACTITIONER EDUCATION

Name of Nurse Practitioner Academic Program

City State Country

Area of Specialization: _____

TYPE OF NURSE PRACTITIONER ACADEMIC PROGRAM:

- ☐ CERTIFICATE
- ☐ MASTERS
- ☐ POST-MASTERS

Entrance Date: _____

Graduation/Completion Date: _____

NAME OF APPLICANT: _____

## NURSE PRACTITIONER PROFESSIONAL CERTIFICATION *(If Applicable)*:

| | |
|---|---|
| Name of Organization/Association<br><br>Area of Specialization: _____<br><br>Certification Number: _____ | METHOD OF CERTIFICATION:<br>☐ EXAMINATION<br>☐ OTHER (Please Explain):<br>Original Date of Certification: _____<br>Current Recertification Cycle Dates: _____ |

## BACKGROUND INFORMATION

| | | |
|---|---|---|
| Have you **applied** for a Nurse Practitioner certificate in California?<br>If yes, name on previous application: _____ Date Submitted: _____ | ☐ YES | ☐ NO |
| Have you ever been **issued** a Nurse Practitioner certificate in California?<br><br>If yes: **STOP! DO NOT CONTINUE.** Please contact the Board regarding whether you should report or file a petition for reinstatement of your California Nurse Practitioner certification. | ☐ YES | ☐ NO |
| Have you ever had disciplinary proceedings against **any** license you hold or **any** health-care related license or certificate including revocation, suspension, probation, voluntary surrender, or any other proceeding in any state or country? If yes, please provide a detailed written explanation, including the date and state or country where the discipline occurred. | ☐ YES | ☐ NO |
| Have you ever been convicted of any offense other than minor traffic violations? If yes, explain fully as described in the applicant instructions. Convictions must be reported even if they have been adjudicated, dismissed or expunged or if a diversion program has been completed. Traffic violations involving driving under the influence, injury to persons or providing false information must be reported. The definition of conviction includes a plea of nolo contendere (no contest), as well as pleas or verdicts of guilty. YOU MUST INCLUDE MISDEMEANOR AS WELL AS FELONY CONVICTIONS. | ☐ YES | ☐ NO |

I understand that I am required to report immediately to the California Board of Registered Nursing if I am convicted of **ANY** offense that occurs between the date of this application and the date that a California registered nurse license is issued. I am also required to report to the California Board of Registered Nursing any disciplinary action and/or voluntary surrender against **ANY** health-care related license/certificate that occurs between the date of this application and the date that a California registered nurse license is issued. I understand that failure to do so may result in denial of this application or subsequent disciplinary action against my license/certificate.

**I certify, under penalty of perjury under the laws of the State of California, that all information provided in connection with this application for licensure is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure or license revocation in California.**

Attach a recent 2"x2" passport type photograph.

Please tape on all four sides.

Head and shoulders only

_____ *SIGNATURE OF APPLICANT*

_____ DATE

**** U.S. SOCIAL SECURITY NUMBER/ITIN DISCLOSURE STATEMENT**

Disclosure of your U.S. Social Security Number/ITIN is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USC section 405(c)(2)(C)) authorizes collection of your U.S. Social Security Number/ITIN. Your U.S. Social Security Number/ITIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and whose licensure is reciprocal with the requesting state. If you fail to disclose your U.S. Social Security Number/ITIN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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# VERIFICATION OF NURSE PRACTITIONER ACADEMIC PROGRAM

TO BE COMPLETED BY APPLICANT: Please complete Section A and forward to the program director/representative for the nurse practitioner academic program for completion. Official transcripts submitted must include all completed coursework with the certificate/degree status conferred and must be sent directly to the Board of Registered Nursing by the Registrar's Office/Transcript Office. A processing fee may be required for the submission of the official transcripts.

## A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number & Street | | DATE OF BIRTH: *(Month/Day/Year)* |
| City / State / Country / Postal/Zip Code | | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES *(Including Maiden)* | MOTHER'S MAIDEN NAME: *(Last Name Only)* |
| E-MAIL ADDRESS: | CALIFORNIA RN LICENSE NUMBER: _____ EXPIRATION DATE: _____ | |
| NAME OF ACADEMIC PROGRAM: | | SPECIALTY: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

## B. TO BE COMPLETED BY THE PROGRAM DIRECTOR/REPRESENTATIVE FOR THE NURSE PRACTITIONER ACADEMIC PROGRAM

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| NAME OF NURSE PRACTITIONER ACADEMIC PROGRAM: | | TELEPHONE NUMBER: ( ) | |
|---|---|---|---|
| ADDRESS: Number & Street | City | State | Postal/Zip Code |

**TYPE OF PROGRAM:**

- ☐ CERTIFICATE
- ☐ MASTERS
- ☐ POST-MASTERS

**SPECIALTY:** _____

**Entrance Date:** _____ *(Month/Day/Year)*

**Completion Date:** _____ *(Month/Day/Year)*

**Date Certificate/Degree Status Conferred:** _____ *(Month/Day/Year)*

**OUT OF STATE NP ACADEMIC PROGRAM GRADUATES:**

**Recognized by Commission on Collegiate Nursing Education:** ☐ YES ☐ NO

**If yes, Name:** _____ **Program Approval Cycle Dates:** _____

**I certify under penalty of perjury that the documentation regarding the completion of the nurse practitioner academic program for the above named applicant is true and correct.**

***SIGNATURE:*** _____ _____ **TITLE:** _____
*(DATE)*

# VERIFICATION OF NURSE PRACTITIONER CERTIFICATION BY NATIONAL ORGANIZATION/ASSOCIATION

## METHOD 2

TO BE COMPLETED BY APPLICANT: Please complete Section A and submit to the applicable national organization/association to verify your nursing practitioner certification status. A fee is required by the national organization/association for the processing of the verification form.

### A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number & Street | | DATE OF BIRTH: *(Month/Day/Year)* |
| City / State / Country / Postal/Zip Code | | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES: *(Including Maiden)* | MOTHER'S MAIDEN NAME: *(First Name Only)* |
| E-MAIL ADDRESS: | CALIFORNIA LICENSE NUMBER: EXPIRATION DATE: | |
| NAME OF ACADEMIC PROGRAM: | SPECIALTY: | |
| ***SIGNATURE OF APPLICANT:*** _____ | | **DATE:** _____ |

### B. TO BE COMPLETED BY THE CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| NAME OF CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION | | TELEPHONE NUMBER: ( ) | |
|---|---|---|---|
| ADDRESS: Number & Street | City | State | Postal/Zip Code |
| METHOD OF CERTIFICATION: | CERTIFICATE NUMBER: | ORIGINAL DATE OF CERTIFICATION: | |
| NURSE PRACTITIONER SPECIALTY AREA: | | | |
| CURRENT RENEWAL CYCLE DATES FOR CERTIFICATION/RECERTIFICATION: *(If not applicable, please explain)* | | From: _____ (Month/Year) To: _____ (Month/Year) | |

**I certify under penalty of perjury that the documentation regarding the nurse practitioner certification status for the above named applicant is true and correct.**

***SIGNATURE:*** _____ _____ **TITLE:** _____
*(DATE)*

*(OFFICIAL SEAL)*

(Rev. 03/2018)

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# VERIFICATION OF "CLINICAL COMPETENCY" AS A NURSE PRACTITIONER

## METHOD 3 - EQUIVALENCY

Verification of the applicant's clinical competency in the delivery of primary care is one of the requirements which must be met in order to qualify to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education and the diagnosis and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(b).*

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care. *(California Code of Regulations Section 1480(c)).*

The verifying nurse practitioner and physician MUST meet the following requirements:

1. **Current, clear and active licensure to practice.**
2. **Clinical competency in the provision of primary care.**
3. **Direct observations of clinical practice.**



### A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: | DATE OF BIRTH: *(Month/Day/Year)* | CALIFORNIA RN LICENSE NUMBER: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

### B. TO BE COMPLETED BY THE EVALUATING "NURSE PRACTITIONER"

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|

| ADDRESS OF AGENCY: Number & Street | City | State | Postal/Zip Code |
|---|---|---|---|
| | | | |

| TELEPHONE NUMBER: | U.S. SOCIAL SECURITY NUMBER: |
|---|---|
| RN LICENSE NUMBER: _____<br>EXPIRATION DATE: _____<br>NP CERTIFICATION NUMBER: _____ | DATES EMPLOYED IN SPECIALTY AREA:<br>From: _____ To: _____<br>PROFESSIONAL SPECIALTY: _____ |
| METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY: | PERIOD OF CLINICAL EVALUATION:<br>From: _____ (Month/Year) To: _____ (Month/Year) |

I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary care.

***SIGNATURE OF EVALUATOR:*** _____ **DATE:** _____

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# VERIFICATION OF "CLINICAL COMPETENCY" AS A NURSE PRACTITIONER

## METHOD 3 - EQUIVALENCY

Verification of the applicant's clinical competency in the delivery of primary care is one of the requirements which must be met in order to qualify to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education and the diagnoses and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(f))*

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, skill, care, and experience ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care. *(California Code of Regulations Section 1480(c))*.

The verifying nurse practitioner and physician MUST meet the following requirements:

1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.



### A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: | DATE OF BIRTH: *(Month/Day/Year)* | CALIFORNIA RN LICENSE NUMBER: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

### B. TO BE COMPLETED BY THE EVALUATING "PHYSICIAN"

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|

| ADDRESS OF AGENCY: Number & Street | City | State | Postal/Zip Code |
|---|---|---|---|
| | | | |

| TELEPHONE NUMBER: | U.S. SOCIAL SECURITY NUMBER: |
|---|---|
| MD LICENSE NUMBER: _____<br>EXPIRATION DATE: _____ | DATES EMPLOYED IN SPECIALTY AREA:<br>From: _____ To: _____<br>PROFESSIONAL SPECIALTY: _____ |
| METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY: | PERIOD OF CLINICAL EVALUATION:<br>From: _____ (Month/Year) To: _____ (Month/Year) |

**I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary care.**

***SIGNATURE OF EVALUATOR:*** _____ **DATE:** _____

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# VERIFICATION OF "CLINICAL EXPERIENCE" AS A NURSE PRACTITIONER

## METHOD 3 - EQUIVALENCY

Verification of the nurse's clinical experience in the delivery of primary care is required in order for him/her to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education and the diagnoses and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(b)).*

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care. *(California Code of Regulations Section 1480(c)).*

The verifying nurse practitioner and physician MUST meet the following requirements:

1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.



### A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: | DATE OF BIRTH: *(Month/Day/Year)* | CALIFORNIA RN LICENSE NUMBER: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

### B. TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER VERIFYING THE APPLICANT'S CLINICAL EXPERIENCE

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| NAME OF AGENCY: | | | |
|---|---|---|---|
| ADDRESS OF AGENCY: Number & Street | City | State | Postal/Zip Code |
| NAME OF APPLICANT'S SUPERVISOR: | SUPERVISOR'S TELEPHONE NUMBER: | | |
| SUPERVISOR'S TITLE: _____<br>LICENSE NUMBER: _____<br>EXPIRATION DATE: _____ | DATES OF SUPERVISOR'S EMPLOYMENT:<br>From: _____ To: _____<br>SPECIALTY AREA: _____ | | |

| DATES OF SUPERVISED CLINICAL EXPERIENCE: | NUMBER OF HOURS: | CLINICAL SPECIALITY: |
|---|---|---|
| From: _____ To: _____ | | |
| From: _____ To: _____ | | |
| From: _____ To: _____ | | |

I certify under penalty of perjury that I have verified that the above named applicant received the number of supervised clinical hours in the appropriate discipline in clinical practice in the performance of diagnostic and treatment procedures essential to the provision of primary care.

***SIGNATURE OF SUPERVISOR:*** _____ ***DATE:*** _____

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# INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

| |
|---|
| Agency Name:<br>**BOARD OF REGISTERED NURSING** |
| Title of official responsible for information maintenance:<br>**EXECUTIVE OFFICER** |
| Address:<br>**P.O. BOX 944210, SACRAMENTO, CA 94244-2100**<br>Telephone Number:<br>**(916) 322-3350** |
| Authority which authorizes the maintenance of the information:<br>**SECTION 30, SECTION 2732.1(a), BUSINESS AND PROFESSIONS CODE** |
| **ALL INFORMATION IS MANDATORY** |
| The consequences, if any of not providing all or any part of the requested information:<br>**FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.** |
| The principal purpose(s) for which the information is to be used:<br>**TO DETERMINE ELIGIBILITY FOR LICENSURE. YOUR U.S. SOCIAL SECURITY NUMBER/ITIN WILL BE USED FOR PURPOSES OF TAX ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 94-455 (42 USC SECTION 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR U.S. SOCIAL SECURITY NUMBER/ITIN. IF YOU FAIL TO DISCLOSE YOUR U.S. SOCIAL SECURITY NUMBER/ITIN, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A $100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST IF AND WHEN YOU BECOME LICENSED.** |
| Any known or foreseeable interagency or intergovernmental transfer which may be made of the information:<br>**POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S. SOCIAL SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.** |
| **EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.** |

# MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a "Mandated Reporter" for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Penal Code Section 11166 and will comply with those provisions.

California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicably possible by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11164 and subsequent sections.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

# APPLICATION FOR TEMPORARY NURSE PRACTITIONER (NP) CERTIFICATE

INSTRUCTIONS:

1. The application fee for the Temporary Nurse Practitioner Certificate (TC/NP) is $150.00.
2. The TC/NP will not be issued until the **Application for Nurse Practitioner Certification** is complete with exception of criminal record clearance from the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).
3. The TC/NP will not be mailed to an in-care-of address or a third party address.
4. Possession of a current and active **California Temporary RN License** (TL) is required.

PLEASE NOTE: IF YOU ALREADY POSSESS A PERMANENT CALIFORNIA RN LICENSE, YOU ARE NOT ELIGIBLE FOR THE TEMPORARY NURSE PRACTITIONER CERTIFICATE (TC/NP) AND YOUR APPLICATION FEE FOR THE TC/NP WILL NOT BE REFUNDED.



## TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | | | MIDDLE NAME: |
|---|---|---|---|---|
| ADDRESS: Number & Street | | | | DATE OF BIRTH: *(Month/Day/Year)* |
| City | State | Country | Postal/Zip Code | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES: *(Including Maiden)* | | | MOTHER'S MAIDEN NAME: *(Last Name Only)* |
| E-MAIL ADDRESS: | | | | TEMPORARY RN LICENSE NUMBER: _____ EXPIRATION DATE: _____ |
| NAME OF NURSE PRACTITIONER ACADEMIC PROGRAM: | | | | |
| ADDRESS: Number & Street | City | State | Postal/Zip Code | |

TYPE OF PROGRAM:

- ☐ CERTIFICATE
- ☐ MASTERS
- ☐ POST-MASTERS

SPECIALTY: _____

ENTRANCE DATE: _____ *(Month/Day/Year)*

COMPLETION DATE: _____ *(Month/Day/Year)*

I certify under penalty of perjury that the above information regarding the Application for the Temporary Nurse Practitioner Certificate is true and correct.

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

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# INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

| |
|---|
| Agency Name:<br>**BOARD OF REGISTERED NURSING** |
| Title of official responsible for information maintenance:<br>**EXECUTIVE OFFICER** |
| Address:<br>**P.O. BOX 944210, SACRAMENTO, CA 94244-2100**<br>Telephone Number:<br>**(916) 322-3350** |
| Authority which authorizes the maintenance of the information:<br>**SECTION 30, SECTION 2732.1(a), BUSINESS AND PROFESSIONS CODE** |
| **ALL INFORMATION IS MANDATORY** |
| The consequences, if any of not providing all or any part of the requested information:<br>**FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.** |
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# NURSE PRACTITIONER FURNISHING NUMBER APPLICATION

APPLICATION FEE - $400.00

☐ MILITARY HONORABLE DISCHARGE - Check here if you served as an active duty member of the Armed Forces of the United States and were honorably discharged.

**PERSONAL DATA** *(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number & Street | | DATE OF BIRTH: *(Month/Day/Year)* |
| City / State / Country / Zip Code | | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:** |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES: *(Including Maiden)* | MOTHER'S MAIDEN NAME: *(Last Name Only)* |
| CA RN LICENSE NUMBER: | CA NP NUMBER: | NP SPECIALTY: |

**NURSE PRACTITIONER ADVANCED PHARMACOLOGY COURSE**

| NAME OF NURSE PRACTITIONER PROGRAM / NAME OF ACADEMIC COURSE: | COURSE TITLE: | COMPLETION DATE: | # QTR/SEM UNITS: |
|---|---|---|---|
| SCHOOL ADDRESS: Number & Street | City | State | Zip Code |

**I certify, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.**

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____



** U.S. SOCIAL SECURITY NUMBER/ITIN DISCLOSURE STATEMENT

Disclosure of your U.S. Social Security Number/ITIN is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USC section 405(c)(2)(C)) authorizes collection of your U.S. Social Security Number/ITIN. Your U.S. Social Security Number/ITIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your U.S. Social Security Number/ITIN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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# NURSE PRACTITIONER
# ADVANCED PHARMACOLOGY COURSE VERIFICATION

In order to furnish drugs and/or devices pursuant to Business and Professions Code, Section 2836.1, the Nurse Practitioner must complete a California Board of Registered Nursing approved advanced pharmacology course. The criteria for the advanced pharmacology course is listed on the two (2) page attachment.

## TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number & Street | | DATE OF BIRTH: *(Month/Day/Year)* |
| City / State / Country / Zip Code | | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES: *(Including Maiden)* | MOTHER'S MAIDEN NAME: *(Last Name Only)* |
| CALIFORNIA RN LICENSE NUMBER: | CA NP NUMBER: | DATES COURSE WAS TAKEN: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

## TO BE COMPLETED BY THE DIRECTOR OF THE NURSE PRACTITIONER ACADEMIC PROGRAM

The above applicant has applied for a Nurse Practitioner furnishing number in California. Please provide the following information and mail to the California Board of Registered Nursing at the above address. The criteria for the advanced pharmacology course is listed on the two (2) page attachment.

| NAME OF NURSE PRACTITIONER PROGRAM: | | | TELEPHONE NUMBER: |
|---|---|---|---|
| ADDRESS: Number & Street | City | State | Zip Code |

**ADVANCED PHARMACOLOGY COURSE/CONTENT:**

**Entrance and completion dates for course:** **Entrance:** _____ *(Month/Day/Year)* **Completion:** _____ *(Month/Day/Year)*

**Was a separate course?** ☐ YES ☐ NO **If YES, specify the course title:** _____

**If NO, was integrated in the program curriculum?** ☐ YES ☐ NO

**Equivalent to: 3 semester units:** ☐ YES ☐ NO **5 quarter units:** ☐ YES ☐ NO **45 hours:** ☐ YES ☐ NO

**The drugs or devices are furnished or ordered by a Nurse Practitioner in accordance with standardized procedures or protocols developed when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.** ☐ YES ☐ NO

**The Advanced Pharmacology course includes the key points and course objectives listed on the two (2) page attachment.** ☐ YES ☐ NO

**I certify under penalty of perjury under the laws of the State of California that the foregoing is true and Correct.**

***SIGNATURE:*** _____ _____ **TITLE:** _____
*(DATE)*

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# NURSE PRACTITIONER ADVANCED PHARMACOLOGY COURSE FOR FURNISHING

These revised guidelines are established for Nurse Practitioner programs who offer advanced pharmacology courses in order to meet Furnishing requirements.

## MINIMUM COURSE OFFERINGS

- A post-RN licensure advanced pharmacology course based on the RN's previous knowledge of pharmacology and pharmacotherapeutics.
- A three (3) semester units or five (5) quarter units academic course.

## KEY POINTS:

The advanced pharmacology course must include:

- The mechanism for ongoing communication between the student and course instructor.
- The requirements for approved standardized procedures to be in place prior to beginning practice.
- The requirement to furnish drugs/devices pursuant to a standardized procedure.
- The furnishing responsibility for Schedule II, III, IV, V controlled substances that are to be furnished with a patient-specific protocol in compliance with the Health and Safety Code (HSC) Division 10, Uniform Controlled Substances Act, Sections 11000-11651, Chapter 1. General Provisions and Definitions, for Nurse Practitioners.
- The furnishing responsibility for Schedule II, III, IV and V controlled substances that are to be furnished with a patient specific protocol in compliance with Health and Safety Code (HSC) Division 10, Uniform Controlled Substances Act, Section 11958 for Certified Nurse Midwives.

## COURSE OBJECTIVES:

1. Uses the data base obtained from the health assessment of the client to identify an appropriate therapeutic regimen, including drugs and/or devices
2. Uses knowledge of pharmacokinetics when developing a therapeutic regimen that maximizes the therapeutic effectiveness while minimizing adverse reactions.
3. Uses knowledge of pharmacodynamics to observe the effects of drugs and/or devices on a client; to predict the client's response; and to understand the effects of the drugs and/or devices.
4. Evaluates the response and compliance of the client to the drugs and/or devices and implement appropriate action.
5. Provides appropriate client education regarding the furnished drugs and/or devices.
6. Furnishes drugs and/or devices pursuant to standardized procedures and in conformance with applicable laws, codes and/or regulations.
7. Examines appropriate guidelines for the pharmacological management of selected health care syndromes/diseases commonly encountered with awareness of client's nutrition, culture, ethnicity and socioeconomic status.
8. Uses knowledge and awareness of the role of herbal and natural remedies while treating disease states.

Advanced Pharmacology Enabling Objectives have been developed through public input and are available upon request.

## FACULTY QUALIFICATIONS

All stated qualifications must be met by the faculty, include Directors and instructors.

- Current, valid and clear license to practice in the appropriate discipline.
- Demonstrates expertise in the theoretical and clinical aspects of pharmacology/pharmacotherapeutics.
- Possesses at least two years of experience in the teaching of advanced pharmacology.
- Includes a faculty member who has completed a doctoral level pharmacology/pharmacotherapeutics degree.
- Demonstrates evidence of advanced clinical practice within the past five years applying the principles of advanced pharmacology.

## ADVANCED PHARMACOLOGY ENABLING OBJECTIVES

- Defines and verbalizes an understanding of the terminology of advanced pharmacology. (Vocabulary list to be included)
- Identifies sources of drugs and provides examples of drugs from each drug source.
- Describes the "targets" of drugs.
- Describes the pharmacokinetic process of absorption, distribution, metabolism, and excretion.
- Identifies factors that alter the processes of absorption, distribution, metabolism, and excretion.
- Analyzes how the body's acid base environment affects the pharmacokinetic process of absorption, distribution, metabolism, and excretion of drugs.
- Describes variables that determine the correct dosages of drugs.
- Defines half-life and explains the importance of a drug's half-life in a therapeutic drug regimen.
- Describes factors that influence a drug's half-life.
- Analyzes the relationship between drugs and the physiological and pathophysiological responses.
- Understands the pharmacologic and pharmacodynamic effects of broad categories of drugs, i.e., antibiotics, antiarrhythmics, anti-hypertensives contraceptives, etc. used in specific treatment regimens.
- Uses data obtained during a client's History and Physical Examination (H&P) to identify appropriate drug choice/s and herbs, vitamins, minerals, and trace elements supplemen/s, and recognizes the role of herbal and natural remedies in the treatment of health and disease states.
- Based upon the principles of pharmacokinetics and pharmacodynamics, identifies the indications, rationale and mechanism of action of drugs and contrasts drugs used to treat specific conditions.
- Understands the potential interactions between drugs and herbs, vitamins, minerals, and trace elements.
- Performs appropriate monitoring before, during, and after specific drug regimens.
- Monitors effects of drugs, evaluates the response and compliance of the client to the drugs/devices and provides interventions for side effects, and manages adverse events that may occur.
- Identifies drugs with a narrow therapeutic range.
- Identifies appropriate methods to write and transmit prescriptions.
- Furnishes drugs pursuant to applicable legal requirements, standardized procedures, and ethical standards.
- Identifies resources for drug information and uses the resources to maintain clinical competency for furnishing.
- Describes the essential components of client education re: medications including: name of medication/s frequency/time of dose/correct dosage/s to take, how to take the medication/s i.e., with or without food, what to do if a dose of a medication is missed, side effects to expect, and adverse event/s to report to the prescriber.
- Identifies factors that influence medication compliance.
- Provides comprehensive and appropriate client and family education re: drugs of choice and alternatives and involves the client and family in the decision making process re: drug treatments.
- Chooses most appropriate drug for a disease base upon client's symptomatology, health status and lifestyle.

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| Address:<br>**P.O. BOX 944210, SACRAMENTO, CA 94244-2100**<br>Telephone Number:<br>**(916) 322-3350** |
| Authority which authorizes the maintenance of the information:<br>**SECTION 30, SECTION 2732.1(a), BUSINESS AND PROFESSIONS CODE** |
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# APPLICATION FOR NURSE PRACTITIONER (NP) CERTIFICATION

APPLICATION FEE - $500.00

☐ MILITARY HONORABLE DISCHARGE - Check here if you served as an active duty member of the Armed Forces of the United States and were honorably discharged.

## PERSONAL DATA *(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number and Street | | |
| City | State | Country | Postal/Zip Code |
| HOME TELEPHONE NUMBER: ( ) | ALTERNATE TELEPHONE NUMBER: ( ) | E-MAIL ADDRESS: |
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## RN LICENSURE / NURSE PRACTITIONER CERTIFICATION

California RN License Number: _____

Date Issued: _____

Expiration Date: _____

List ALL States Where You Hold/Held an RN License and Status:

List ALL States Where You Hold/Held a Nurse Practitioner License/Certificate and Status:

## RN EDUCATION

Name of Professional Registered Nursing Program

City State Country

TYPE OF PROGRAM:

- ☐ ASSOCIATE DEGREE
- ☐ DIPLOMA
- ☐ BACCALAUREATE DEGREE
- ☐ MASTERS DEGREE/NURSING

Entrance Date: _____

Graduation/Completion Date: _____

## NURSE PRACTITIONER EDUCATION

Name of Nurse Practitioner Academic Program

City State Country

Area of Specialization: _____

TYPE OF NURSE PRACTITIONER ACADEMIC PROGRAM:

- ☐ CERTIFICATE
- ☐ MASTERS
- ☐ POST-MASTERS

Entrance Date: _____

Graduation/Completion Date: _____

NAME OF APPLICANT: _____

## NURSE PRACTITIONER PROFESSIONAL CERTIFICATION *(If Applicable)*:

| | |
|---|---|
| _____<br>Name of Organization/Association<br><br>Area of Specialization: _____<br><br>Certification Number: _____ | METHOD OF CERTIFICATION:<br>☐ EXAMINATION<br>☐ OTHER (Please Explain):<br><br>Original Date of Certification: _____<br><br>Current Recertification Cycle Dates: _____ |

## BACKGROUND INFORMATION

| | | |
|---|---|---|
| Have you **applied** for a Nurse Practitioner certificate in California?<br>If yes, name on previous application: _____ Date Submitted: _____ | ☐ YES | ☐ NO |
| Have you ever been **issued** a Nurse Practitioner certificate in California?<br><br>If yes: **STOP! DO NOT CONTINUE.** Please contact the Board regarding whether you should apply or file a petition for reinstatement of your California Nurse Practitioner certificate. | ☐ YES | ☐ NO |
| Have you ever had disciplinary proceedings against **any** license as a nurse or **any** health-care related license or certificate including revocation, suspension, probation, voluntary surrender or any other proceeding in any state or country? If yes, please provide a detailed written explanation, including the date and state or country where the discipline occurred. | ☐ YES | ☐ NO |
| Have you ever been convicted of any offense other than minor traffic violations? If yes, explain fully as described in the applicant instructions. Convictions must be reported even if they have been adjudicated, dismissed or expunged or if a diversion program has been completed. Traffic violations involving driving under the influence, injury to persons or providing false information must be reported. The definition of conviction includes a plea of nolo contendere (no contest), as well as pleas or verdicts of guilty. YOU MUST INCLUDE MISDEMEANOR AS WELL AS FELONY CONVICTIONS. | ☐ YES | ☐ NO |

I understand that I am required to report immediately to the California Board of Registered Nursing if I am convicted of **ANY** offense that occurs between the date of this application and the date that a California registered nurse license is issued. I am also required to report to the California Board of Registered Nursing any disciplinary action and/or voluntary surrender against **ANY** health-care related license/certificate that occurs between the date of this application and the date that a California registered nurse license is issued. I understand that failure to do so may result in denial of this application or subsequent disciplinary action against my license/certificate.

**I certify, under penalty of perjury under the laws of the State of California, that all information provided in connection with this application for licensure is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure or license revocation in California.**

Attach a recent 2"x2" passport type photograph.

Please tape on all four sides.

Head and shoulders only

_____ _____

*SIGNATURE OF APPLICANT* DATE

**** U.S. SOCIAL SECURITY NUMBER/ITIN DISCLOSURE STATEMENT**

Disclosure of your U.S. Social Security Number/ITIN is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USC section 405(c)(2)(C)) authorizes collection of your U.S. Social Security Number/ITIN. Your U.S. Social Security Number/ITIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your U.S. Social Security Number/ITIN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

# VERIFICATION OF NURSE PRACTITIONER ACADEMIC PROGRAM

TO BE COMPLETED BY APPLICANT: Please complete Section A and forward to the program director/representative for the nurse practitioner academic program for completion. Official transcripts submitted must include all completed coursework with the certificate/degree status conferred and must be sent directly to the Board of Registered Nursing by the Registrar's Office/Transcript Office. A processing fee may be required for the submission of the official transcripts.

## A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number & Street | | DATE OF BIRTH: *(Month/Day/Year)* |
| City / State / County / Postal/Zip Code | | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES: *(Including Maiden)* | MOTHER'S MAIDEN NAME: *(Last Name Only)* |
| E-MAIL ADDRESS: | | CALIFORNIA RN LICENSE NUMBER: _____ EXPIRATION DATE: _____ |
| NAME OF ACADEMIC PROGRAM: | | SPECIALTY: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

## B. TO BE COMPLETED BY THE PROGRAM DIRECTOR/REPRESENTATIVE FOR THE NURSE PRACTITIONER ACADEMIC PROGRAM

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| NAME OF NURSE PRACTITIONER ACADEMIC PROGRAM: | | | TELEPHONE NUMBER: ( ) |
|---|---|---|---|
| ADDRESS: Number & Street | City | State | Postal/Zip Code |

**TYPE OF PROGRAM:**

- ☐ CERTIFICATE
- ☐ MASTERS
- ☐ POST-MASTERS

**SPECIALTY:** _____

**Entrance Date:** _____ *(Month/Day/Year)*

**Completion Date:** _____ *(Month/Day/Year)*

**Date Certificate/Degree Status Conferred:** _____ *(Month/Day/Year)*

**OUT OF STATE NP ACADEMIC PROGRAM GRADUATES:**

**Recognized by Commission on Collegiate Nursing Education:** ☐ YES ☐ NO

**If yes, Name:** _____ **Program Approval Cycle Dates:** _____

**I certify under penalty of perjury that the documentation regarding the completion of the nurse practitioner academic program for the above named applicant is true and correct.**

***SIGNATURE:*** _____ _____ **TITLE:** _____
*(DATE)*

# VERIFICATION OF NURSE PRACTITIONER CERTIFICATION BY NATIONAL ORGANIZATION/ASSOCIATION

## METHOD 2

TO BE COMPLETED BY APPLICANT: Please complete Section A and submit to the applicable national organization/association to verify your nursing practitioner certification status. A fee is required by the national organization/association for the processing of the verification form.

### A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number & Street | | DATE OF BIRTH: *(Month/Day/Year)* |
| City / State / Country / Postal/Zip Code | | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES: *(Include Maiden)* | MOTHER'S MAIDEN NAME: *(Last Name Only)* |
| E-MAIL ADDRESS: | | CALIFORNIA RN LICENSE NUMBER: _____ EXPIRATION DATE: _____ |
| NAME OF ACADEMIC PROGRAM: | | SPECIALTY: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

### B. TO BE COMPLETED BY THE CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| NAME OF CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION | | TELEPHONE NUMBER: ( ) | |
|---|---|---|---|
| ADDRESS: Number & Street | City | State | Postal/Zip Code |
| METHOD OF CERTIFICATION | CERTIFICATE NUMBER: | ORIGINAL DATE OF CERTIFICATION: | |
| NURSE PRACTITIONER SPECIALTY AREA | | | |
| CURRENT RENEWAL CYCLE DATES FOR CERTIFICATION/RECERTIFICATION: *(If not applicable, please explain)* | | From: _____ (Month/Year) To: _____ (Month/Year) | |

**I certify under penalty of perjury that the documentation regarding the nurse practitioner certification status for the above named applicant is true and correct.**

***SIGNATURE:*** _____ _____ **TITLE:** _____
*(DATE)*

*(OFFICIAL SEAL)*

(Rev. 03/2019)

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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# VERIFICATION OF "CLINICAL COMPETENCY" AS A NURSE PRACTITIONER

## METHOD 3 - EQUIVALENCY

Verification of the applicant's clinical competency in the delivery of primary care is one of the requirements, which must be met in order to qualify to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education and the diagnoses and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(h))*

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care. *(California Code of Regulations Section 1480(c))*.

The verifying nurse practitioner and physician MUST meet the following requirements:

1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.

### A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: | DATE OF BIRTH: *(Month/Day/Year)* | CALIFORNIA RN LICENSE NUMBER: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

### B. TO BE COMPLETED BY THE EVALUATING "NURSE PRACTITIONER"

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|

| ADDRESS OF AGENCY: Number & Street | City | State | Postal/Zip Code |
|---|---|---|---|
| | | | |

| TELEPHONE NUMBER: | U.S. SOCIAL SECURITY NUMBER: |
|---|---|
| RN LICENSE NUMBER: _____<br>EXPIRATION DATE: _____<br>NP CERTIFICATION NUMBER: _____ | DATES EMPLOYED IN SPECIALTY AREA:<br>From: _____ To: _____<br>PROFESSIONAL SPECIALTY: _____ |
| METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY: | PERIOD OF CLINICAL EVALUATION:<br>From: _____ (Month/Year) To: _____ (Month/Year) |

**I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary care.**

***SIGNATURE OF EVALUATOR:*** _____ **DATE:** _____

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# VERIFICATION OF "CLINICAL COMPETENCY" AS A NURSE PRACTITIONER

## METHOD 3 - EQUIVALENCY

Verification of the applicant's clinical competency in the delivery of primary care is one of the requirements, which must be met in order to qualify to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education and the diagnoses and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(b))*

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care. *(California Code of Regulations Section 1480(c))*.

The verifying nurse practitioner and physician MUST meet the following requirements:

1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.

### A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: | DATE OF BIRTH: *(Month/Day/Year)* | CALIFORNIA RN LICENSE NUMBER: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

### B. TO BE COMPLETED BY THE EVALUATING "PHYSICIAN"

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| | | |

| ADDRESS OF AGENCY: Number & Street | City | State | Postal/Zip Code |
|---|---|---|---|
| | | | |

| TELEPHONE NUMBER: | U.S. SOCIAL SECURITY NUMBER: |
|---|---|
| MD LICENSE NUMBER: _____<br>EXPIRATION DATE: _____ | DATES EMPLOYED IN SPECIALTY AREA:<br>From: _____ To: _____<br>PROFESSIONAL SPECIALTY: _____ |
| METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY: | PERIOD OF CLINICAL EVALUATION:<br>From: _____ (Month/Year) To: _____ (Month/Year) |

I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary care.

***SIGNATURE OF EVALUATOR:*** _____ **DATE:** _____

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# VERIFICATION OF "CLINICAL EXPERIENCE" AS A NURSE PRACTITIONER

## METHOD 3 - EQUIVALENCY

Verification of the nurse's clinical experience in the delivery of primary care is required in order for him/her to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education and the diagnoses and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(b))*

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care. *(California Code of Regulations Section 1480(c))*.

The verifying nurse practitioner and physician MUST meet the following requirements:

1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.

### A. TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: | DATE OF BIRTH: *(Month/Day/Year)* | CALIFORNIA RN LICENSE NUMBER: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

### B. TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER VERIFYING THE APPLICANT'S CLINICAL EXPERIENCE

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| NAME OF AGENCY: | | | |
|---|---|---|---|
| ADDRESS OF AGENCY: Number & Street | City | State | Postal/Zip Code |
| NAME OF APPLICANT'S SUPERVISOR: | SUPERVISOR'S TELEPHONE NUMBER: | | |
| SUPERVISOR'S TITLE: _____<br>LICENSE NUMBER: _____<br>EXPIRATION DATE: _____ | DATES OF SUPERVISOR'S EMPLOYMENT:<br>From: _____ To: _____<br>SPECIALTY AREA: _____ | | |
| DATES OF SUPERVISED CLINICAL EXPERIENCE:<br>From: _____ To: _____<br>From: _____ To: _____<br>From: _____ To: _____ | NUMBER OF HOURS: | CLINICAL SPECIALITY: | |

I certify under penalty of perjury that I have verified that the above named applicant received the number of supervised clinical hours in the appropriate discipline in clinical practice in the performance of diagnostic and treatment procedures essential to the provision of primary care.

***SIGNATURE OF SUPERVISOR:*** _____ ***DATE:*** _____

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# INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

| |
|---|
| Agency Name:<br>**BOARD OF REGISTERED NURSING** |
| Title of official responsible for information maintenance:<br>**EXECUTIVE OFFICER** |
| Address:<br>**P.O. BOX 944210, SACRAMENTO, CA 94244-2100**<br>Telephone Number:<br>**(916) 322-3350** |
| Authority which authorizes the maintenance of the information:<br>**SECTION 30, SECTION 2732.1(a) BUSINESS AND PROFESSIONS CODE** |
| **ALL INFORMATION IS MANDATORY.** |
| The consequences, if any, of not providing all or any part of the requested information:<br>**FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.** |
| The principal purpose(s) for which the information is to be used:<br>**TO DETERMINE ELIGIBILITY FOR LICENSURE. YOUR U.S. SOCIAL SECURITY NUMBER/ITIN WILL BE USED FOR PURPOSES OF TAX ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 94-455 (42 USC SECTION 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR U.S. SOCIAL SECURITY NUMBER/ITIN. IF YOU FAIL TO DISCLOSE YOUR U.S. SOCIAL SECURITY NUMBER/ITIN, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A $100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST IF AND WHEN YOU BECOME LICENSED.** |
| Any known or foreseeable interagency or intergovernmental transfer which may be made of the information:<br>**POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S. SOCIAL SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.** |
| **EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.** |

# MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a "Mandated Reporter" for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Penal Code Section 11166 and will comply with those provisions.

California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practically possible by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11164, and subsequent sections.

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# APPLICATION FOR TEMPORARY NURSE PRACTITIONER (NP) CERTIFICATE



INSTRUCTIONS:

1. The application fee for the Temporary Nurse Practitioner Certificate (TC/NP) is $150.00.
2. The TC/NP will not be issued until the **Application for Nurse Practitioner Certification** is complete with exception of criminal record clearance from the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).
3. The TC/NP will not be mailed to an in-care-of address or a third party address.
4. Possession of a current and active California Temporary RN License (TL) is required.

PLEASE NOTE: IF YOU ALREADY POSSESS A PERMANENT CALIFORNIA RN LICENSE, YOU ARE NOT ELIGIBLE FOR THE TEMPORARY NURSE PRACTITIONER CERTIFICATE (TC/NP) AND YOUR APPLICATION FEE FOR THE TC/NP WILL NOT BE REFUNDED.

## TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number & Street | | DATE OF BIRTH: *(Month/Day/Year)* |
| City / State / Country / Postal/Zip Code | | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES: *(Including Maiden)* | MOTHER'S MAIDEN NAME: *(Last Name Only)* |
| E-MAIL ADDRESS: | TEMPORARY RN LICENSE NUMBER: _____ EXPIRATION DATE: _____ | |
| NAME OF NURSE PRACTITIONER ACADEMIC PROGRAM: | | |
| ADDRESS: Number & Street | City / State / Postal/Zip Code | |
| TYPE OF PROGRAM: ☐ CERTIFICATE ☐ MASTERS ☐ POST-MASTERS SPECIALTY: _____ | ENTRANCE DATE: _____ *(Month/Day/Year)* COMPLETION DATE: _____ *(Month/Day/Year)* | |

I certify under penalty of perjury that the above information regarding the Application for the Temporary Nurse Practitioner Certificate is true and correct.

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

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| |
|---|
| Agency Name:<br>**BOARD OF REGISTERED NURSING** |
| Title of official responsible for information maintenance:<br>**EXECUTIVE OFFICER** |
| Address:<br>**P.O. BOX 944210, SACRAMENTO, CA 94244-2100**<br>Telephone Number:<br>**(916) 322-3350** |
| Authority which authorizes the maintenance of the information:<br>**SECTION 30, SECTION 2732.1(a), BUSINESS AND PROFESSIONS CODE** |
| **ALL INFORMATION IS MANDATORY.** |
| The consequences, if any, of not providing all or any part of the requested information:<br>**FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.** |
| The principal purpose(s) for which the information is to be used:<br>**TO DETERMINE ELIGIBILITY FOR LICENSURE. YOUR U.S. SOCIAL SECURITY NUMBER/ITIN WILL BE USED FOR PURPOSES OF TAX ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 94-455 (42 USC SECTION 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR U.S. SOCIAL SECURITY NUMBER/ITIN. IF YOU FAIL TO DISCLOSE YOUR U.S. SOCIAL SECURITY NUMBER/ITIN, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A $100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST IF AND WHEN YOU BECOME LICENSED.** |
| Any known or foreseeable interagency or intergovernmental transfer which may be made of the information:<br>**POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S. SOCIAL SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.** |
| **EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.** |

# MANDATORY REPORTER

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California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practically possible by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11164, and subsequent sections.

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# NURSE PRACTITIONER FURNISHING NUMBER APPLICATION

APPLICATION FEE - $400.00

☐ MILITARY HONORABLE DISCHARGE - Check here if you served as an active duty member of the Armed Forces of the United States and were honorably discharged.

**PERSONAL DATA** *(PRINT OR TYPE)*

| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| ADDRESS: Number & Street | | DATE OF BIRTH: *(Month/Day/Year)* |
| City / State / Country / Zip Code | | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:** |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES: *(Including Maiden)* | MOTHER'S MAIDEN NAME: *(Last Name Only)* |
| CA RN LICENSE NUMBER: | CA NP NUMBER: | NP SPECIALTY: |

**NURSE PRACTITIONER ADVANCED PHARMACOLOGY COURSE**

| NAME OF NURSE PRACTITIONER PROGRAM / NAME OF ACADEMIC COURSE: | COURSE TITLE: | COMPLETION DATE: | # QTR/SEM UNITS: |
|---|---|---|---|
| SCHOOL ADDRESS: Number & Street | City | State | Zip Code |

**I certify, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.**

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

** U.S. SOCIAL SECURITY NUMBER/ITIN DISCLOSURE STATEMENT

Disclosure of your U.S. Social Security Number/ITIN is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USC section 405(c)(2)(C)) authorizes collection of your U.S. Social Security Number/ITIN. Your U.S. Social Security Number/ITIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your U.S. Social Security Number/ITIN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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# NURSE PRACTITIONER
# ADVANCED PHARMACOLOGY COURSE VERIFICATION

In order to furnish drugs and/or devices pursuant to Business and Professions Code, Section 2836.1, the Nurse Practitioner must complete a California Board of Registered Nursing approved advanced pharmacology course. The criteria for the advanced pharmacology course is listed on the two (2) page attachment.

## TO BE COMPLETED BY APPLICANT

*(PRINT OR TYPE)*

| | | |
|---|---|---|
| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
| ADDRESS: Number & Street | | DATE OF BIRTH: *(Month/Day/Year)* |
| City / State / Country / Zip Code | | U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: |
| TELEPHONE NUMBER: Home ( ) Alternate ( ) | PREVIOUS NAMES: *(Including Maiden)* | MOTHER'S MAIDEN NAME: *(Last Name Only)* |
| CALIFORNIA RN LICENSE NUMBER: | CA NP NUMBER: | DATES COURSE WAS TAKEN: |

***SIGNATURE OF APPLICANT:*** _____ **DATE:** _____

## TO BE COMPLETED BY THE DIRECTOR OF THE NURSE PRACTITIONER ACADEMIC PROGRAM

The above applicant has applied for a Nurse Practitioner furnishing number in California. Please provide the following information and mail to the California Board of Registered Nursing at the above address. The criteria for the advanced pharmacology course is listed on the two (2) page attachment.

| | | | |
|---|---|---|---|
| **NAME OF NURSE PRACTITIONER PROGRAM:** | | | **TELEPHONE NUMBER:** |
| **ADDRESS:** Number & Street | **City** | **State** | **Zip Code** |

**ADVANCED PHARMACOLOGY COURSE CONTENT:**

**Entrance and completion dates for course: Entrance:** _____ *(Month/Day/Year)* **Completion:** _____ *(Month/Day/Year)*

**Was a separate course?** ☐ YES ☐ NO **If YES, specify the course title:** _____

**If NO, was integrated in the program curriculum?** ☐ YES ☐ NO

**Equivalent to: 3 semester units:** ☐ YES ☐ NO **5 quarter units:** ☐ YES ☐ NO **45 hours:** ☐ YES ☐ NO

**The drugs or devices are furnished or ordered by a Nurse Practitioner in accordance with standardized procedures or protocols developed when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.** ☐ YES ☐ NO

**The Advanced Pharmacology course includes the key points and course objectives listed on the two (2) page attachment.** ☐ YES ☐ NO

**I certify under penalty of perjury under the laws of the State of California that the foregoing is true and Correct.**

***SIGNATURE:*** _____ _____ **TITLE:** _____
*(DATE)*

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR GAVIN NEWSOM

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
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# NURSE PRACTITIONER ADVANCED PHARMACOLOGY COURSE FOR FURNISHING

These revised guidelines are established for Nurse Practitioner programs who offer advanced pharmacology courses in order to meet Furnishing requirements.

## MINIMUM COURSE OFFERINGS

- A post-RN licensure advanced pharmacology course based on the RN's previous knowledge of pharmacology and pharmacotherapeutics.
- A three (3) semester units or five (5) quarter units academic course.

## KEY POINTS:

The advanced pharmacology course must include:

- The mechanism for ongoing communication between the student and course instructor.
- The requirements for approved standardized procedures to be in place prior to beginning practice.
- The requirement to furnish drugs/devices pursuant to a standardized procedure.
- The furnishing responsibility for Schedule II, III, IV, V controlled substances that are to be furnished with a patient-specific protocol in compliance with the Health and Safety Code (HSC) Division 10, Uniform Controlled Substances Act, Sections 11000-11651, Chapter 1. General Provisions and Definitions, for Nurse Practitioners.
- The furnishing responsibility for Schedule II, III, IV and V controlled substances that are to be furnished with a patient specific protocol in compliance with Health and Safety Code (HSC) Division 10, Uniform Controlled Substances Act, Section 11056, for Certified Nurse Midwives.

## COURSE OBJECTIVES:

1. Uses the data base obtained from the health assessment of the client to identify an appropriate therapeutic regimen, including drugs and/or devices.
2. Uses knowledge of pharmacokinetics when developing a therapeutic regimen that maximizes the therapeutic effectiveness while minimizing adverse reactions.
3. Uses knowledge of pharmacodynamics to observe the effects of drugs and/or devices on a client; to predict the client's response; and to understand the effects of the drugs and/or devices.
4. Evaluates the response and compliance of the client to the drugs and/or devices and implement appropriate action.
5. Provides appropriate client education regarding the furnished drugs and/or devices.
6. Furnishes drugs and/or devices pursuant to standardized procedures and in conformance with applicable laws, codes and/or regulations.
7. Examines appropriate guidelines for the pharmacological management of selected health care syndromes/diseases commonly encountered with awareness of client's nutrition, culture, ethnicity and socioeconomic status.
8. Uses knowledge and awareness of the role of herbal and natural remedies while treating disease states.

Advanced Pharmacology Enabling Objectives have been developed through public input and are available upon request.

## FACULTY QUALIFICATIONS

All stated qualifications must be met by the faculty, include Directors and instructors.

- Current, valid and clear license to practice in the appropriate discipline.
- Demonstrates expertise in the theoretical and clinical aspects of pharmacology/pharmacotherapeutics.
- Possesses at least two years of experience in the teaching of advanced pharmacology.
- Includes a faculty member who has completed a doctoral level pharmacology/pharmacotherapeutics degree.
- Demonstrates evidence of advanced clinical practice within the past five years applying the principles of advanced pharmacology.

## ADVANCED PHARMACOLOGY ENABLING OBJECTIVES

- Defines and verbalizes an understanding of the terminology of advanced pharmacology. (Vocabulary list to be included)
- Identifies sources of drugs and provides examples of drugs from each drug source.
- Describes the "targets" of drugs.
- Describes the pharmacokinetic process of absorption, distribution, metabolism, and excretion.
- Identifies factors that alter the processes of absorption, distribution, metabolism, and excretion.
- Analyzes how the body's acid base environment affects the pharmacokinetic process of absorption, distribution, metabolism, and excretion of drugs.
- Describes variables that determine the correct dosages of drugs.
- Defines half-life and explains the importance of a drug's half-life in a therapeutic drug regimen.
- Describes factors that influence a drug's half-life.
- Analyzes the relationship between drugs and their physiological and pathophysiological responses.
- Understands the pharmacokinetic and pharmacodynamic effects of broad categories of drugs, i.e., antibiotics, antiarrhythmics, antihypertensives contraceptives, etc. used in specific treatment regimens.
- Uses data obtained during a client's History and Physical Examination (H&P) to identify appropriate drug choice/s and dosages, vitamins, minerals, and trace elements regimen/s, and recognizes the role of herbal and other remedies in the treatment of health and disease states.
- Based upon the principles of pharmacokinetics and pharmacodynamics, identifies the indications, rationale, and mechanism of action of drugs and contrasts drugs used to treat specific conditions.
- Understands the potential interactions between drugs and herbs, vitamins, minerals, and trace elements.
- Performs appropriate monitoring before, during, and after drug regimens.
- Monitors efficacy of drug/s evaluates the response and compliance of the client to the drugs/devices and provides interventions for side effects, and manages adverse events that may occur.
- Identifies drugs with narrow therapeutic ranges.
- Identifies appropriate methods to write and transmit prescriptions.
- Furnishes drugs pursuant to applicable legal requirements, standardized procedures, and ethical standards.
- Identifies resources for drug information and uses the resources to maintain clinical competency for furnishing.
- Describes the essential components of client education re: medications including: name of medication/s frequency, time of doses, correct dosage/s to take, how to take the medication/s i.e., with or without food, what to do if dose of a medication is missed, side effects to expect, and adverse event/s to report to the prescriber.
- Identifies factors that influence medication compliance.
- Provides comprehensive and appropriate client and family education re: drugs of choice and alternatives and involves the client and family in the decision making process re: drug treatments.
- Chooses most appropriate drug for a disease base upon client's symptomatology, health status and lifestyle.

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# INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

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| Agency Name:<br>**BOARD OF REGISTERED NURSING** |
| Title of official responsible for information maintenance:<br>**EXECUTIVE OFFICER** |
| Address:<br>**P.O. BOX 944210, SACRAMENTO, CA 94244-2100**<br>Telephone Number:<br>**(916) 322-3350** |
| Authority which authorizes the maintenance of the information:<br>**SECTION 30, SECTION 2732.1(a) BUSINESS AND PROFESSIONS CODE** |
| **ALL INFORMATION IS MANDATORY.** |
| The consequences, if any, of not providing all or any part of the requested information:<br>**FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.** |
| The principal purpose(s) for which the information is to be used:<br>**TO DETERMINE ELIGIBILITY FOR LICENSURE. YOUR U.S. SOCIAL SECURITY NUMBER/ITIN WILL BE USED FOR PURPOSES OF TAX ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 94-455 (42 USC SECTION 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR U.S. SOCIAL SECURITY NUMBER/ITIN. IF YOU FAIL TO DISCLOSE YOUR U.S. SOCIAL SECURITY NUMBER/ITIN, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A $100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST IF AND WHEN YOU BECOME LICENSED.** |
| Any known or foreseeable interagency or intergovernmental transfer which may be made of the information:<br>**POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S. SOCIAL SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.** |
| **EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.** |

# MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a "Mandated Reporter" for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Penal Code Section 11166 and will comply with those provisions.

California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicably possible by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both imprisonment and fine.

For further details about these requirements consult Penal Code Section 11164, and subsequent sections.