



**BOARD OF REGISTERED NURSING**  
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### ONLINE CLINICAL NURSE SPECIALIST APPLICANT IDENTIFICATION FORM

You must complete and submit this form with the required supporting documents to:  
Board of Registered Nursing, ATTN: Advanced Practice Unit, P.O. Box 944210, Sacramento, CA 94244-2100.

<b>APPLICATION NUMBER: 4003</b>		
<b>Print Full Name:</b> _____ <small>(Last)</small>	_____ <small>(First)</small>	_____ <small>(Middle)</small>
<b>U.S. Social Security Number or Individual Taxpayer Identification Number:</b> _____	<b>E-Mail:</b> _____	
<b>Address:</b> _____	<b>Date of Birth:</b> _____	
<b>Name of Clinical Nurse Program:</b> _____		
<b>City, State and Country of Clinical Nurse Specialist Program:</b> _____		
<b>INDICATE ALL FEES PAID ONLINE BY CREDIT CARD:</b>		
<input type="checkbox"/> Application fee - \$150.00		
<b>HAVE YOU COMPLETED AND/OR ENCLOSED THE FOLLOWING ITEMS (check all that apply):</b>		
Have you attached a recent 2" x 2" <b>passport type photograph</b> ?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If applicable, is supplemental information regarding reporting prior convictions or discipline against licenses enclosed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I certify under penalty of perjury under the laws of the State of California, that all information provided in connection with this online 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.		
<b>Signature of Applicant:</b> _____	<div style="border: 2px solid black; padding: 10px; text-align: center;"><b>Tape Your 2" x 2" Passport Type Photograph Here</b></div>	
<b>Date:</b> _____		