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
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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** **Area of Specialization:** _____ **Certification Number:** _____	**METHOD OF CERTIFICATION:** ☐ **EXAMINATION** ☐ **OTHER (Please Explain):** **Original Date of Certification:** _____ **Current Recertification Cycle Dates:** _____

BACKGROUND INFORMATION

Have you **applied** for a Nurse Practitioner certificate in California? If yes, name on previous application: _____ Date Submitted: _____	YES	NO
Have you ever been **issued** a Nurse Practitioner certificate in California? If yes: **STOP! DO NOT CONTINUE.** Please contact the Board regarding whether you should reapply or file a petition for reinstatement of your California Nurse Practitioner certification.	YES	NO
Have you ever had disciplinary proceedings against **any** license as a RN 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

I understand that I am required to report immediately 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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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:** *(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)

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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 "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: _____ **EXPIRATION DATE:** _____ **NP CERTIFICATION NUMBER:** _____	**DATES EMPLOYED IN SPECIALTY AREA:** **From:** _____ **To:** _____ **PROFESSIONAL SPECIALTY:** _____		
METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY:	**PERIOD OF CLINICAL EVALUATION:** **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: _____ **EXPIRATION DATE:** _____	**DATES EMPLOYED IN SPECIALTY AREA:** **From:** _____ **To:** _____ **PROFESSIONAL SPECIALTY:** _____
METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY:	**PERIOD OF CLINICAL EVALUATION:** **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: _____ **LICENSE NUMBER:** _____ **EXPIRATION DATE:** _____	**DATES OF SUPERVISOR'S EMPLOYMENT:** **From:** _____ **To:** _____ **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: **BOARD OF REGISTERED NURSING**
Title of official responsible for information maintenance: **EXECUTIVE OFFICER**
Address: **P.O. BOX 944210, SACRAMENTO, CA 94244-2100** — Telephone Number: **(916) 322-3350**
Authority which authorizes the maintenance of the information: **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: **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: **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: **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.