

INSTRUCTIONS FOR THE APRN LICENSURE APPLICATION

FAX COPIES OF APPLICATIONS WILL NOT BE ACCEPTED BY KBN

General Information ***PLEASE PRINT CLEARLY IN BLACK INK***

- Licensure fees and regulatory requirements are subject to change. Fees are NON-REFUNDABLE:
Initial - \$169.25 Reinstatement - \$139.25
- Validation of name change(s) is required if the name on any document received at KBN is different from the name on the application for licensure. Acceptable validations include a copy of either a:
 1. Social security card,
 2. Marriage license, **OR**
 3. Court order or divorce decree showing the right to a name change.
- You are required to notify KBN within 30 days of an address change. The notification must include:
 1. Name
 2. Social security number or Kentucky nursing license number
 3. New address
- The application is valid for one year from the date received at KBN.
- Practicing without a permanent Kentucky APRN license may subject you to disciplinary action by KBN.
- It is your responsibility to assure that all documents have been received **BEFORE** the application for APRN licensure expires.

National Certification Requirements

- Current certification from a KBN-recognized national certifying organization is a requirement for all APRNs.
 - KBN conducts periodic audits for current national certification.
 - **NO** grace period is given by KBN for practicing as an APRN when national certification and/or APRN licensure has lapsed.
- Continuing to practice as an APRN after your national certification has lapsed may subject you to disciplinary action by KBN.

Section 1: Biographical Data

- All information must be provided.
- KBN does not distribute/provide email addresses to third parties.

Section 2: Method of Application/Designation

- Check the appropriate box to indicate if this is your ***initial*** (first) Kentucky APRN license or if you are reinstating your Kentucky APRN license.
 - **Initial:**
 - You hold a current Kentucky RN license and are requesting Kentucky APRN licensure.
 - You hold a current multistate/compact RN license and are requesting Kentucky APRN licensure.
 - **Reinstatement:**
 - You hold a current Kentucky RN license and are requesting reinstatement of your Kentucky APRN license.
 - You hold a current multistate/compact RN license and are requesting Kentucky APRN licensure.
- Check the appropriate box to indicate your APRN designation.

Section 3: Nursing Practice and Primary Residence

- Evidence of primary residence includes: 1) Voter registration, 2) Driver's license, 3) Federal income tax return and/or 4) Military Form No. 2058.
- DO NOT submit evidence of primary residence unless requested to do so.
- Submit validation of current RN licensure with application.

Section 4: Disciplinary

- All questions must be answered. If you answer "yes" to any of these questions, your application will not be processed until the following documents are received:
 1. A detailed letter of explanation for each action taken.
 2. A certified copy of the Board's or other licensing agency's action.
- Failure to report any action pending or disciplinary action **EVER** taken on a nursing license or other professional license may subject you to disciplinary action.
- Failure to report participation in an alternative to discipline/diversion program may subject you to disciplinary action.

Section 5: Criminal History

- All questions must be answered. You **MUST REPORT** the following and submit the required documents:
 1. All felony convictions ever received (submit Certified Court Documents & Detailed Letter of Explanation)
 2. All misdemeanor(s) received WITHIN 5 years of the date of application (submit Certified Court Documents & Detailed Letter of Explanation)
 3. All DUIs (submit Certified Court Documents & Detailed Letter of Explanation)
 4. All misdemeanor(s) received PRIOR TO 5 years of the date of application (MUST REPORT, but no documents required)
- NOTE: Traffic violations OTHER than DUIs do not need to be reported.
- If you answered "**YES**" to any question(s), allow 3 months for all information to be reviewed by KBN.
- Failure to report any criminal convictions **EVER** received may subject you to disciplinary action.

Section 6: APRN Educational Program Information

- List your APRN program of nursing information.
- Enter month and year graduated.
- Indicate whether your program of nursing included a supervised clinical practicum.
- Indicate the degree/credential earned for initial APRN licensure.
- Submit evidence of completion of **advanced practice** nursing education:
 1. Applicants who completed post-basic APRN education **after** January 1, 2005:
 - a. Must request your advanced practice program of nursing to send KBN an official transcript with the degree and date posted.
 - b. Must hold either a:
 - Master's degree, **OR**
 - Post-masters' certificate from a college or university awarding related APRN credits, **OR**
 - Doctorate of Nursing Practice
 2. Applicants who completed post-basic APRN education **prior to** January 1, 2005:
 - a. Nurse Practitioners and Clinical Nurse Specialists must request their advanced practice program of nursing to send KBN an official transcript with the degree and date posted.
 - b. Nurse Anesthetists and Nurse Midwives may submit a copy of:
 - A diploma,
 - A certificate of graduation, **OR**
 - An official transcript with degree and date posted.

Section 7: National Certification or Recertification

- Indicate month and year certification expires.
- Check the appropriate box that indicates your national certifying organization or the one to which you have applied.
- Indicate whether your national certification has ever been revoked or issued on a provisional status. If you answer “yes”, you must submit a detailed letter of explanation.
- Include a copy of a current certification/recertification card. *
- A **membership card** to a national certifying organization is **not acceptable**.
- Include a copy of your active RN license, or other validation of current RN licensure.
- Indicate whether you have been licensed, certified, or registered as an advanced registered nurse practitioner for at least one year prior to filing this application.
- If you hold national certification in more than one specialty and want KBN records to reflect all specialties, please contact the APRN Coordinator at (502) 429-3329.

* Certification/recertification card must include:
1. Your name
2. Certification number
3. Expiration date
4. Specialty type
5. National certification organization’s name

Section 8: Reinstatement of a Kentucky APRN License

- Indicate whether your national certification has ever been revoked or issued on a provisional status. If you answer “Yes” to this question, you must submit a detailed letter of explanation.

Return to KBN:

- Completed application
- Fee of \$139.25 (\$120 application fee + \$19.25 fingerprint card fee)
- Kentucky Criminal History Report, obtained by the Administrative Office of the Courts
- Completed Fingerprint Card
- A copy of your current certification/recertification card

Section 9: Responsibility & Accountability of KY Licensed Nurses

- Please read carefully before signing this application.
- Falsification of any information contained herein may be cause for disciplinary action by KBN.
- The portion of nursing law cited in this section relating to KRS 314.021 explains the accountability and responsibility of all nurses licensed to practice nursing in Kentucky.
- All licensed nurses practicing in Kentucky must adhere to the Kentucky Nursing Laws and regulations, which are available at <http://kbn.ky.gov/laws.htm>.
- It is a violation of Kentucky Nursing Law to practice as an Advanced Practice Registered Nurse with an expired national certification, RN license, and/or APRN license.

APPLICATION FOR LICENSURE AS AN ADVANCED PRACTICE REGISTERED NURSE

APPLICATION FEE IS NON-REFUNDABLE AND SUBJECT TO CHANGE

Office Use Only

Section 1: Biographical Data

Last Name (print clearly)

First Name (print clearly)

Middle Name (print clearly)

Male Female

Maiden Name (print clearly)

Social Security # (print clearly)

Date of Birth

U.S. Citizen? Yes No

Address (print clearly)

City (print clearly)

State

Zip Code (print clearly)

County of Residence (print clearly)

International Country (not USA) (print clearly)

International Postal Code (print clearly)

Daytime Phone Number (print clearly)

Home Phone Number (print clearly)

Email Address (print clearly)

Ethnic Group:

- African American Native American
 Asian Pacific Islander
 Multiracial Caucasian
 Hispanic or Latino/a Other

Indicate Your Primary State of Residence: KY Other: _____

Do you practice nursing ONLY in a military/federal facility? Yes No

Section 2: Method of Application/Designation

MAKE CHECK OR MONEY ORDER PAYABLE TO KENTUCKY BOARD OF NURSING

If You Have Never Held a KY APRN License

Initial (A1): \$150 Fee and \$19.25 Fingerprint Card Fee

Complete These Sections

1, 2, 3, 4, 5, 6, 7, 9, 10

Submit

Kentucky Criminal History Report and Fingerprint Card

If You Held a KY APRN License

Reinstatement (A3): \$120 Fee and \$19.25 Fingerprint Card Fee

Complete These Sections

1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Submit

Kentucky Criminal History Report and Fingerprint Card

APRN Designation: Anesthetist (3) Midwife (4) Practitioner (5) Clinical Specialist (6)

Section 3: Nursing Practice and Primary Residence

Do you hold a current RN license? Yes No If yes, what state? _____ **Submit validation of a current RN license.**

Indicate Your Primary State of Residence: KY Other: _____ Do you practice nursing ONLY in a military/federal facility? Yes No
DO NOT SUBMIT EVIDENCE OF PRIMARY RESIDENCE UNLESS REQUESTED TO DO SO.

Check the box for EACH state in which you currently practice:

- | | | | | | | | | | | | | | |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> AL | <input type="checkbox"/> AZ | <input type="checkbox"/> DC | <input type="checkbox"/> GU | <input type="checkbox"/> IL | <input type="checkbox"/> LA | <input type="checkbox"/> MI | <input type="checkbox"/> MT | <input type="checkbox"/> NH | <input type="checkbox"/> NY | <input type="checkbox"/> PA | <input type="checkbox"/> SD | <input type="checkbox"/> VA | <input type="checkbox"/> WI |
| <input type="checkbox"/> AK | <input type="checkbox"/> CA | <input type="checkbox"/> DE | <input type="checkbox"/> HI | <input type="checkbox"/> IN | <input type="checkbox"/> MA | <input type="checkbox"/> MN | <input type="checkbox"/> NC | <input type="checkbox"/> NJ | <input type="checkbox"/> OH | <input type="checkbox"/> PR | <input type="checkbox"/> TN | <input type="checkbox"/> VI | <input type="checkbox"/> WV |
| <input type="checkbox"/> AR | <input type="checkbox"/> CO | <input type="checkbox"/> FL | <input type="checkbox"/> IA | <input type="checkbox"/> KS | <input type="checkbox"/> MD | <input type="checkbox"/> MO | <input type="checkbox"/> ND | <input type="checkbox"/> NM | <input type="checkbox"/> OK | <input type="checkbox"/> RI | <input type="checkbox"/> TX | <input type="checkbox"/> VT | <input type="checkbox"/> WY |
| <input type="checkbox"/> AS | <input type="checkbox"/> CT | <input type="checkbox"/> GA | <input type="checkbox"/> ID | <input type="checkbox"/> KY | <input type="checkbox"/> ME | <input type="checkbox"/> MS | <input type="checkbox"/> NE | <input type="checkbox"/> NV | <input type="checkbox"/> OR | <input type="checkbox"/> SC | <input type="checkbox"/> UT | <input type="checkbox"/> WA | |

Section 4: Disciplinary

If you answer "yes" to any of these questions, your application will not be processed until the following documents are received:

1. A detailed letter of explanation for each action taken.
2. A certified copy of the Board's or other licensing agency's action.

Check the appropriate boxes and fill out information for each "yes" answer: If yes, list STATE and YEAR If yes, list STATE and YEAR

- | | | | |
|---|--|--|--------------------------|
| Have you ever been denied a nursing license (for reasons other than failure to pass State Board Exam/NCLEX)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | State: _____ Year: _____ | State: _____ Year: _____ |
| Have you ever had any disciplinary action on your nursing license or your privilege to practice nursing in any state(s)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | State: _____ Year: _____ | State: _____ Year: _____ |
| Do you have disciplinary action or a complaint pending on your nursing license or your privilege to practice in any state(s)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | State: _____ Year: _____ | State: _____ Year: _____ |
| Are you currently a participant in a state board/designee monitoring program including alternative to discipline, diversion, or a peer assistance program? | <input type="checkbox"/> Yes <input type="checkbox"/> No | State: _____ Year: _____ | State: _____ Year: _____ |
| Has any licensing or regulatory authority in any U.S. state or jurisdiction EVER denied, limited, suspended, probated, revoked, or otherwise disciplined a nursing or other professional or occupational license, certificate or multi-state privilege to practice that you held? | <input type="checkbox"/> Yes <input type="checkbox"/> No | State: _____ Year: _____ | State: _____ Year: _____ |
| | | If Yes, type of license(s)/certification(s): _____ | |
| | | _____ | |

Section 5: Criminal History

You must REPORT: Your application will not be processed until you SUBMIT the required documents listed below:

1. All felony convictions ever received.....Certified Court Documents & Detailed Letter of Explanation
2. All misdemeanor(s) received WITHIN 5 years of the date of applicationCertified Court Documents & Detailed Letter of Explanation
3. All DUIs.....Certified Court Documents & Detailed Letter of Explanation
4. All misdemeanor(s) received PRIOR TO 5 years of the date of application.....MUST REPORT, but No Documents Required

NOTE: Traffic violations OTHER than DUIs do not need to be reported.

	If yes, list STATE and YEAR	If yes, list STATE and YEAR
Have you ever been convicted of a misdemeanor(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	State: _____ Year: _____	State: _____ Year: _____

Type of conviction: _____

	If yes, list STATE and YEAR	If yes, list STATE and YEAR
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Have you ever been convicted of a felony(ies)? <input type="checkbox"/> Yes <input type="checkbox"/> No	State: _____ Year: _____	State: _____ Year: _____
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Since you last applied for or were issued a Kentucky nursing license, have you had any misdemeanors or felonies? Yes No

Section 6: APRN Educational Program Information

Answer the following questions about the advanced practice nursing program you attended.
See the instruction sheet for transcript requirements.

_____ / _____
Program for Initial Advanced Practice Nurse Licensure (print clearly)

_____ / _____ / _____
City (print clearly) State Country (if not USA) (print clearly)

_____ / _____ Did the program include a supervised clinical practicum? Yes No
Month & Year Graduated

Degree/Credential Earned for Initial APRN Licensure: Diploma/Certificate Master's Post-Master's Doctorate

Section 7: National Certification or Recertification

DESIGNATION

Advanced Practice Designation: Anesthetist (3) Midwife (4) Nurse Practitioner (5) Clinical Specialist (6)

NATIONAL CERTIFICATION ORGANIZATION AND POPULATION FOCUS

- American Assn. of Nurse Anesthetists American Midwifery Certification Board American Nurses Credentialing Center
 Pediatric Nursing Certification Board American Academy of Nurse Practitioners National Certification Corporation
 American Assn. of Critical Care Nurses

Select Population Focus: Anesthetist (1) Pediatric (5) Child/Adol Psy/Mental Health (11)
 Midwife (2) Women's Health (6) Neonatal (12)
 Adult (3) Gerontological (7) Acute Care (13)
 Family (4) Adult Psy/Mental Health (10) Family Psy/Mental Health (17)

Certification Number

Certification Expiration Date

You must enclose a copy of your current certification card.

Have you been licensed or registered as an advanced practice registered nurse for at least one year? Yes No

If yes, give state, month and year of initial APRN licensure:

_____ / _____ / _____
State Month Year

Has your national certification ever been revoked or issued on a provisional/conditional status? Yes No
If yes, submit a detailed letter of explanation.

If you hold national certification in more than one population focus and want KBN records to reflect all population foci, please contact the APRN Coordinator at (502) 429-3329.

Section 8: Reinstatement of a Kentucky APRN License

Has your national certification ever been revoked or issued on a provisional/conditional status? Yes No
If yes, submit a detailed letter of explanation.

Enclose:

- Completed application and fee
- Completed Fingerprint Card and fee
- Kentucky Criminal History Report
- Copy of national certification card

Section 9: Responsibility and Accountability of KY Licensed Nurses

KRS 314.021(2): All individuals licensed under provisions of this chapter shall be responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing and shall practice nursing with reasonable skill and safety.

All licensed nurses practicing in Kentucky must adhere to the Kentucky Nursing Laws and regulations, which are available at <http://kbn.ky.gov/laws.htm>

KRS 314.031(1): It is "unlawful for any person to call or hold herself or himself out as or use the title of nurse or to practice or offer to practice as a nurse unless licensed or privileged under the provisions of this chapter."

Section 10: Attestation Statement

I certify that I am the person referred to in the foregoing application for licensure as an Advanced Practice Registered Nurse (APRN) in Kentucky; that I am not in default of a student loan or I am in repayment status of a student loan administered by the Kentucky Higher Education Assistance Authority (KHEAA); that I am not delinquent in the repayment of a defaulted Nursing Incentive Scholarship Fund award administered by KBN; that I must have and maintain national certification to practice as an APRN; that all statements contained herein and on all attachments are true and correct in every respect, and that I have read and understand this application and all requirements stated therein. I understand that all information on this application is subject to an audit for verification and that the falsification of any information contained herein will be cause for disciplinary action. I further understand that to practice as an APRN on an expired national certification violates Kentucky Nursing Law and subjects me to disciplinary action. I declare my primary state of residence to be the state as indicated in Section 3 of this application.

Applicant's Signature

_____ / _____ / _____

Date