Kentucky Board of Nursing
312 Whittington Pky Ste 300
Louisville KY 40222-5172
502-429-3300 800-305-2042

APPLICATION FOR LICENSURE AS AN ADVANCED PRACTICE REGISTERED NURSE

APPLICATION FEE IS NON-REFUNDABLE AND SUBJECT TO CHANGE

370

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)

Ethnic Group:

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

Daytime Phone Number (print clearly) Home Phone Number (print clearly)

Email Address (print clearly)

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/Role Designation

APPLICATION FEES PAYABLE BY CHECK OR MONEY ORDER TO THE KENTUCKY BOARD OF NURSING

If You Have Never Held a KY APRN License		Complete These Sections	Submit to KBN
☐ Initial (A1):	$165 Fee	1, 2, 3, 4, 5, 6, 7, 9, 10	Kentucky Criminal History Report

If You Held a KY APRN License		Complete These Sections	Submit to KBN
☐ Reinstatement (A3):	$135 Fee	1, 2, 3, 4, 5, 7, 8, 9, 10	Kentucky Criminal History Report

FINGERPRINT FEE PAYABLE BY CHECK OR MONEY ORDER TO THE KENTUCKY STATE POLICE
See the enclosed Fingerprint Instruction Sheet for fingerprint fee and mailing instructions.

APRN Role Designation: ☐ Anesthetist (3) ☐ Midwife (4) ☐ Practitioner (5) ☐ Clinical Nurse 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:

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

Section 4: Disciplinary

If you answer "Yes" to any of these questions, you **SHALL** provide the following documents:

1. A detailed letter of explanation for each action taken.
2. A certified copy of the Board's or other licensing agency's action.
3. If you have more than two disciplinary events, please list the event(s) and include state and year received on a separate piece of paper. Mail all documentation to the KBN address.

Check the appropriate boxes and fill out information for each "Yes" answer:

1. Do you have a current investigation pending on your nursing license, other professional license/certification or your privilege to practice in any state(s)/jurisdiction(s) other than with KBN? ☐ Yes ☐ No

   State: ______ Year: ______ State: ______ Year: ______

   If "Yes", has this been previously reported to KBN? ☐ Yes ☐ No

2. Are you currently a participant in a state board/designee monitoring program including alternative to discipline, diversion, or a peer assistance program other than with KBN? ☐ Yes ☐ No

   State: ______ Year: ______ State: ______ Year: ______

   If "Yes", has this been previously reported to KBN? ☐ Yes ☐ No

3. Has any licensing or regulatory authority in any state(s)/ jurisdiction(s), other than KBN, EVER denied, limited, suspended, probated, revoked, or otherwise disciplined your nursing or other professional license/certification or your privilege to practice? ☐ Yes ☐ No

   State: ______ Year: ______ If "Yes", type of license/certification: ______________________

   State: ______ Year: ______ If "Yes", type of license/certification: ______________________

   If "Yes", has this been previously reported to KBN? ☐ Yes ☐ No

Section 5: Criminal History

** Per KRS 314.011 (21) Convictions include conditional discharge, a guilty plea pursuant to pretrial diversion, pleading no contest, nolo contendre or entered an Alford plea*

If you have more than two felony or misdemeanor convictions, please list the conviction and state and year received on a separate piece of paper. Mail all documentation to the KBN address.

<u>You shall report ALL felony convictions* and provide certified court records and a detailed letter of explanation.</u>

1. Have you EVER been convicted of a felony? ☐ Yes ☐ No

   State: ______ Year: ______ If "Yes", type of felony: ______________________

   State: ______ Year: ______ If "Yes", type of felony: ______________________

   If yes, has this conviction been previously reported to KBN? ☐ Yes ☐ No

Section 5: Criminal History (Continued) *• Per KRS 314.011 (21) Convictions include conditional discharge, a guilty plea pursuant to pretrial diversion, pleading no contest, nolo contendre or entered an Alford plea*

You shall report ALL misdemeanor convictions*

2. Have you EVER been convicted of a misdemeanor including DUI's? ☐ Yes ☐ No
   - If the conviction* (including DUI's) is less than five years old, you shall provide certified court records and a detailed letter of explanation.
   - If the conviction* (including DUI's) is more than five years old, no additional documentation is required unless requested by KBN..

State: _______ Year: _______ If Yes, type of misdemeanor: ______________________________

State: _______ Year: _______ If Yes, type of misdemeanor: ______________________________

If yes, has this conviction been previously reported to KBN? ☐ 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.

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Program for Initial Advanced Practice Nurse Licensure (print clearly)

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| |_|_| |_|_|_|_|_|_|_|_|_|_|

City (print clearly) **State** **Country (if not USA)** (print clearly)

|_|_| / |_|_|_|_|

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

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

Section 7: APRN Role Designation and National Certification

ROLE DESIGNATION

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

NATIONAL CERTIFICATION ORGANIZATION AND POPULATION FOCUS:

☐ American Midwifery Certification Board
☐ Pediatric Nursing Certification Board
☐ National Certification Corporation
☐ American Nurses Credentialing Center
☐ American Academy of Nurse Practitioners Certification Program
☐ National Board of Certification and Recertification for Nurse Anesthetists
☐ American Association of Critical Care Nurses Certification Corporation

Select Population Focus:

☐ **Anesthetist** ☐ **Midwife**

Nurse Practitioners:

☐ Adult Acute Care ☐ Adult Primary Care ☐ Adult Gerontology Acute Care
☐ Adult Gerontology Primary Care ☐ Family ☐ Gerontological
☐ Neonatal ☐ Pediatric Acute Care ☐ Pediatric Primary Care
☐ Women's Health ☐ Adult Psych/Mental Health ☐ Psych/Mental Health-Lifespan

Clinical Nurse Specialists:

☐ Acute Care-Lifespan ☐ Adult ☐ Adult Gerontology
☐ Gerontological ☐ Neonatal ☐ Pediatric
☐ Child/Adol Psych/Mental Health ☐ Adult Psych/Mental Health ☐ Psych/Mental Health-Lifespan

Certification Number ______________________ Certification Expiration Date ____________________

Please provide a copy of your current certification card. If you hold national certification in more than one population focus and want KBN records to reflect all population foci, please contact the APRN Licensure Coordinator at (502) 429-3329.

Section 7: APRN Role Designation and National Certification (Continued)

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 ___

Section 8: Reinstatement of a Kentucky APRN License

Enclose:

- Completed application and fee
- Completed Fingerprint Card and fee (both submitted directly to the Kentucky State Police – See Fingerprint Instruction Sheet for fingerprint fee and mailing instructions).
- 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 shall adhere to the Kentucky Nursing Laws and regulations, which are available at http://kbn.ky.gov/legalopinions/Pages/laws.aspx.

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 this application; 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 shall 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 failure to comply with requirements for licensure may subject this application to denial status. I understand that all information on this application is subject to an audit for verification and that knowingly supplying false information on or with this application is a violation of KRS Chapter 314 and may subject me to the full range of disciplinary action described therein. I further understand that to practice as an APRN on expired national certification violates Kentucky Nursing Law and may subject me to disciplinary action. I declare my primary state of residence to be the state as indicated in the 'Declaration of Primary Residence' Section of this application.

____

Applicant's Signature

_______ / _______ / _______

Date