

## DISTRICT OF COLUMBIA BOARD OF NURSING ADVANCED PRACTICE REGISTERED NURSE APPLICATION

### PLEASE READ BEFORE COMPLETING THE APPLICATION AND RETAIN FOR YOUR RECORDS

Your interest in becoming licensed as an Advance Practice Registered Nurse in the District of Columbia is welcomed. We look forward to providing expedient and professional service. However, the quality of our service is dependent on the completeness of your application.

#### APPLICATION PROCESS

- You will receive an email that your application has been received and is currently being processed. Please allow **15 business days** from the receipt of the notification before checking the status of your application. You must register to check your application status at: <https://app.hpla.doh.dc.gov/mylicense/>
- Once your application has been reviewed and you are deemed eligible for a temporary license, it will automatically be issued. License applications that do not indicate conviction or discipline history will be eligible for temporary licensure status. You may view your temporary licensure status at: <https://app.hpla.doh.dc.gov/weblookup/>
- If additional information is required to complete your application, you will be contacted via email by a Licensing Specialist with instructions on how to submit the required documents. Please be sure to submit the required documents in the manner requested.
- An application that remains incomplete for ninety (90) days or more from the date of submission shall be considered abandoned, and closed by the Board. The applicant shall thereafter be required to reapply, comply with the current requirements for licensure, and pay the required fees.

#### IMPORTANT CONTACT INFORMATION

##### **DC Board of Nursing Location:**

District of Columbia Department of Health  
899 North Capitol Street NE  
Washington, D.C. 20002

##### **Website:**

[dchealth.dc.gov/bon](https://dchealth.dc.gov/bon)

##### **Board of Nursing Email:**

[bon.dc@dc.gov](mailto:bon.dc@dc.gov)

##### **Mailing Address:**

D.C. Board of Nursing  
P.O. Box 37802  
Washington, D.C. 20013

**BEFORE YOU SUBMIT YOUR APPLICATION MAKE SURE YOU HAVE PROVIDED OR REQUESTED ALL OF THE FOLLOWING APPLICATION CHECKLIST ITEMS:**

**APPLICATION CHECKLIST**

**ADDING AN ADVANCED PRACTICE AUTHORITY TO AN ACTIVE DC RN LICENSE**

- A completed, signed and dated application
- \$230.00 application fee (non-refundable)
- Email address
- Name change document- If the name on your application differs from the name on any of your supporting documents, proof of name change is required. Acceptable documents are: marriage certificate, divorce decree, court order or spouse's death certificate.
- A copy of a government issued photo ID
- Criminal background check (**Required if your previous background check with the DC Board of Nursing is older than four years**). Criminal background check instructions can be found on the Board of Nursing's site([dchealth.dc.gov/bon](http://dchealth.dc.gov/bon)) under **Criminal background check**.
- Verification of APRN certification. Contact your certifying body and request that proof of current certification is emailed to the Board of Nursing. Each certifying body has the Board of Nursing's contact and email information on record.

**REGISTERED NURSE /ADVANCED PRACTICE NURSE – NOT LICENSED IN DC**

- A completed, signed and dated application
- \$375.00 application fee (non-refundable)
- Two 2x2 size passport-type photos
- Social Security number or signed affidavit
- Email address
- Name change document- If the name on your application differs from the name on any of your supporting documents, proof of name change is required. Acceptable documents are: marriage certificate, divorce decree, court order or spouse's death certificate.

- A copy of a government issued photo ID
- Criminal background check. Criminal background check instructions can be found on the Board of Nursing's site ([dchealth.dc.gov/bon](http://dchealth.dc.gov/bon)) under [Criminal background check](#).
- Verification of licensure from the original state. If the original state is expired, verification is required from both the original and a current state.

**To submit verification of your RN licensure status access NURSYS.COM.** If your state does not participate in the NURSYS verification system, request that verification be emailed to the DC Board of Nursing. Our email address is on file with each non-participating state board of nursing.

**Non-NURSYS Participating Boards** (Alabama; California; Michigan; Pennsylvania)

- Verification of APRN certification. Contact your certifying body and request that proof of current certification is emailed to the Board of Nursing. Each certifying body has the Board of Nursing's contact and email information on record

### **REGISTERED NURSE /ADVANCED PRACTICE NURSE – ADDING ADDITIONAL AUTHORITY TO AN ACTIVE ADVANCED PRACTICE REGISTERED NURSE LICENSE**

- A completed, signed and dated application
- \$119.00 application fee (non-refundable)
- Email address
- Name change document- If the name on your application differs from the name on any of your supporting documents, proof of name change is required. Acceptable documents are: marriage certificate, divorce decree, court order or spouse's death certificate.
- A copy of a government issued photo ID
- Criminal background check (**Required if your previous background check with the DC Board of Nursing is older than four years**). Criminal background check instructions can be found on the Board of Nursing's site ([dchealth.dc.gov/bon](http://dchealth.dc.gov/bon)) under [Criminal background check](#).
- Verification of APRN certification. Contact your certifying body and request that proof of current certification is emailed to the Board of Nursing. Each certifying body has the Board of Nursing's contact and email information on record.

**PLEASE RETAIN FOR YOUR RECORDS**

## BOARD OF NURSING ADVANCED PRACTICE REGISTERED NURSE

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514. If you have any questions, call HPLA Customer Service at 1-877-672-2174 Monday through Friday, 8:30 AM to 4:30 PM EST.

**Please Note: Please refer to application instructions before completing this form.**

### SECTION 1. LICENSURE TYPE & FEES NON-REFUNDABLE

**ACTIVE DC REGISTERED NURSE- DC LICENSE NUMBER \_\_\_\_\_**  
**ADDING ADVANCED PRACTICE AUTHORITY CHECK ONE \$230.00**

- CLINICAL NURSE SPECIALIST
- NURSE ANESTHETIST
- NURSE MIDWIFE
- NURSE PRACTITIONER

**REGISTERED NURSE /ADVANCED PRACTICE NURSE – NOT LICENSED IN DC CHECK ONE \$375.00**

- CLINICAL NURSE SPECIALIST
- NURSE ANESTHETIST
- NURSE MIDWIFE
- NURSE PRACTITIONER

**REGISTERED NURSE /ADVANCED PRACTICE NURSE – ADDING ADDITIONAL AUTHORITY TO AN ACTIVE ADVANCED PRACTICE REGISTERED NURSE LICENSE \$119.00**

- CLINICAL NURSE SPECIALIST
- NURSE ANESTHETIST
- NURSE MIDWIFE
- NURSE PRACTITIONER

**CRIMINAL BACKGROUND CHECK:** Each new applicant for licensure shall obtain a criminal background check. **If you are adding an authority to an active DC Registered Nurse license, a criminal background check is required only if the previous background check with the DC Board of Nursing is older than four years.**

**LICENSURE EXPIRATION:** All licenses expire **June 30<sup>th</sup>** of even numbered years

**Make check or money order payable to:** DC Treasurer

**Mail your application to:**

D.C. Board of Nursing

P.O. Box 37802

Washington, D.C. 20013

**SECTION 2. APPLICANT INFORMATION**

**Note: LEGAL NAME: (Do not use any initials unless they are a part of your name)**

\_\_\_\_\_  
FIRST NAME                      MI                      LAST NAME                      ( SUFFIX: Jr., Sr. etc.)

\_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \*                      GENDER:  MALE  FEMALE

Date of Birth                      Social Security Number

**\*All Applicants must provide a Social Security Number. If you are a foreign graduate and do not have a SSN or are waiting for one to be issued, you must complete the SSN affidavit form and submit it with your application. Your license will not be renewed without a valid SSN.**

**SECTION 3. OTHER NAMES USED: (Please print clearly)**

If your name on this application is different from the name on your supporting documentation, provide a copy of a legal document supporting the name change. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders and spouse's death certificate.

\_\_\_\_\_  
FIRST NAME                      MI                      LAST NAME                      (SUFFIX: Jr., Sr. etc.)

\_\_\_\_\_  
FIRST NAME                      MI                      LAST NAME                      (SUFFIX: Jr., Sr. etc.)

\_\_\_\_\_  
Place of Birth: State/Province/Territory                      Country if not USA

**SECTION 4: RACE & ETHNICITY DESIGNATION:**

- American Indian/Alaskan Native     Asian/South Asian     Black or African American
- Caucasian/White     Hispanic or Latino
- Other \_\_\_\_\_     Native Hawaiian or other Pacific Islander

**LANGUAGE(S) SPOKEN:**

- Language(s) spoken other than English:
- Spanish                       French
- German                       Arabic
- Other \_\_\_\_\_

**SECTION 5. HOME /BUSINESS ADDRESS**

**Note: A P.O. BOX MAY NOT BE USED FOR AN ADDRESS. PLEASE PROVIDE A STREET ADDRESS.**

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

HOME ADDRESS                       BUSINESS ADDRESS

Home Address or  DC Local/Mailing Address

ADDRESS: \_\_\_\_\_  
(Street Number and Street Name)                      (City)                      (State/Province/Territory)                      (Zip Code)

APARTMENT # \_\_\_\_\_                      PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_                      FAX: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**You are statutorily required to notify the DC Board of Nursing in writing of an address change within 30 days. Failure to do may result in your not receiving your license, renewal notice or other official notices and can result in a disciplinary action or a fine.**

EMAIL ADDRESS (REQUIRED): \_\_\_\_\_                      CELL PHONE: \_\_\_\_\_

Business Address

ADDRESS: \_\_\_\_\_  
(Street Number and Street Name)                      (City)                      (State/Province/Territory)                      (Zip Code)

APARTMENT # \_\_\_\_\_                      PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_                      FAX: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_                      CELL PHONE: \_\_\_\_\_

<b>SECTION 6. NURSING SCHOOLS ATTENDED</b>		
List all nursing schools that you have attended beginning with the most recent at the top.		
School Name, City, State, Country	Date of Graduation mm/yyyy	Degree/Certificate

<b>SECTION 7. PROFESSIONAL LICENSURE IN OTHER JURISDICTIONS</b>			
MANDATORY FIELD	JURISDICTION	ACTIVE/ NOT ACTIVE	LICENSE NUMBER
Original state of licensure:			
Current state of licensure:			

**VERIFYING LICENSURE STATUS (FOR APPLICANTS WHO ARE NOT LICENSED AS RNs IN DC)**

**You must provide verification of licensure from the original state. If the original state is expired, verification is required from both the original and current states of licensure.**

**To submit verification of your licensure status access NURSYS.COM.** If your state does not participate in the NURSYS verification system, request that verification be emailed to the DC Board of Nursing. Our email address is on file with each non-participating state board of nursing.

**Non-NURSYS Participating Boards** (Alabama; California; Michigan; Pennsylvania)

<b>SECTION 8. CERTIFICATION</b>		
Credentialing Body- AANPCB, ANCC, PNCB, AMCB, NBCRNA, AACN, CCNS, NCC	Certification Title-	Certification Number

**(Credentialing Bodies listed on the next page of this application)**

**DISTRICT OF COLUMBIA BOARD OF NURSING RECOGNIZED ADVANCED PRACTICE REGISTERED NURSE CERTIFICATION PROGRAMS**

- **AACN- American Association of Critical Care Certification Corporation**
  - **AACNS-N** Neonatal CNS wellness through acute care
  - **ACCNS-P** Pediatric CNS wellness through acute care
  - **CCNS-AG** Adult/Gero CNS wellness through acute care **AG-ACNPC** Adult/Gero Acute Care CNP
  
- **AANPCB- American Association of Nurse Practitioners Certification Board**
  - **NP-C** Family Nurse Practitioner NP-C
  - **NP-C** Adult/Gero Primary Care Nurse Practitioner
  
- **AMCB- American Midwifery Certification Board CNM Certified nurse midwife**
  
- **ANCC- American Nurses Credentialing Center**
  - **AGACNP-BC** Adult/Gero Acute Care Nurse Practitioner
  - **AGPCNP-BC** Adult/Gero Primary Care Nurse Practitioner
  - **FNP-BC** Family Nurse Practitioner
  - **PPCNP-BC** Pediatric Primary Care Nurse Practitioner
  - **PMHNP-BC** Family Psychiatric and Mental Health Nurse Practitioner
  
- **NBCRNA- National Board on Certification and Recertification of Nurse Anesthetists CRNA Certified Registered Nurse Anesthetist**
  
- **NCC -National Certification Corporation WHNP-BC Women's Healthcare Nurse Practitioner NNP-BC Neonatal Nurse Practitioner**
  
- **PNCB- Pediatric Nursing Certification Board CPNP-PC Pediatric Nurse Practitioner Primary Care CPNP-AC Pediatric Nurse Practitioner Acute Care**

**PLEASE RETAIN FOR YOUR RECORDS**

**SECTION 9. SCREENING QUESTIONS Applicants must answer all of the following questions**

**Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement**

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your license** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

**PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be issued a license if you have failed to file your District tax returns.**

**IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.**

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

Information presented above is in compliance with the requirement to submit with your application for licensure under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

YES NO

A Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

YES NO

B Do you have a mental condition that currently impairs your ability to practice your profession?

YES NO

C Have you ever been convicted or arrested for a crime or misdemeanor (other than a minor traffic violation)?

YES NO

D Have you been terminated from or resigned from a clinical or professional training program due to a practice issue?

YES NO

E Please answer with respect to DC or any other jurisdiction/state:

- (1) Have you withdrawn an application to practice your profession or voluntarily surrendered a license after formal charges have been filed against you or while under investigation?
- (2) Has any authority or peer review board taken adverse action against your license or privileges or informed you of any pending charges not previously reported to this Board?
- (3) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law?
- (4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board?
- (5) Have you voluntarily surrendered your license?
- (6) Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility?

YES NO

F Have you been party to a malpractice action or had a malpractice action brought against you?

YES NO

**SECTION 11. LICENSEE AFFIDAVIT**

*I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.*

\_\_\_\_\_  
**LICENSEE SIGNATURE**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**DATE**

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.

**SOCIAL SECURITY AFFIDAVIT FORM**

First Name:	MI	Last Name:
Address		
City:	State:	Zip code:
Email:	Date of Birth:	

In accordance with D.C. Official Code § 3-1205.05(b) a Social Security number is required to be placed on the application for licensure or certification. In accordance with § 466(a) (13) of the Social Security Act if you do not have a Social Security number at the time of application, you must submit a sworn affidavit, under penalty of perjury, stating that you do not have a Social Security number. If you were not born in the United States and depending on your immigration status you may not be eligible for a Social Security number. Please be advised that a Tax ID number (beginning with the number “9” and having a “7” as the fourth digit) will not suffice as a permanent substitute for a Social Security number.

**ATTESTATION: By signing this Affidavit, I acknowledge my understanding agreement with the following:**

1. As soon as I become eligible, I will apply for a Social Security Number. Immediately upon my receipt of a Social Security Number, I will provide to the Board, in writing at the address listed below, my valid Social Security Number and a copy of my Social Security card, or any other document issued by the Social Security Administration, as evidence of my Social Security Number.
2. I understand that if I fail to supply my valid Social Security Number to the Board before my District of Columbia license/certification expires, the Board shall not renew my license/certification until I provide my valid Social Security Number and, under such circumstances, I hereby WAIVE my right to renew my license until such time as I have provided my valid Social Security Number to the Board.
3. In accordance with D.C. Official Code § 3-1205.13(b) I will inform the Board within thirty (30) days of any change in my address.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

Sworn to and subscribed before me this \_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Notary Public