Who is Eligible to Apply for Licensure by Endorsement?

Section 464.009, Florida Statutes allows for three (3) different methods to qualify for licensure by endorsement.

(1) The department shall issue the appropriate license by endorsement to practice professional or practical nursing to an applicant who, upon applying to the department …., demonstrates to the board that he or she:

Have you taken the State Board Test Pool Exam (SBTPE) or NCLEX examination? Do you have an active license in another U.S. state or territory?

(a) Holds a valid license to practice professional or practical nursing in another state or territory of the United States, provided that, when the applicant secured his or her original license, the requirements for licensure were substantially equivalent to or more stringent than those existing in Florida at that time;

Have you taken the SBTPE or NCLEX examination, but do not have an active license in another U.S. state or territory?

(b) Meets the qualifications for licensure in Section 464.008 (Florida Statutes) and has successfully completed a state, regional, or national examination which is substantially equivalent to or more stringent than the examination given by the department; or

Are you an applicant who has not taken the SBPTE or NCLEX? Have you practiced as a nurse in another U.S. state or territory for 24 of the last 36 months?

(c) Has actively practiced nursing in another state, jurisdiction, or territory of the United States for 2 of the preceding 3 years without having his or her license acted against by the licensing authority of any jurisdiction. Applicants who become licensed pursuant to this paragraph must complete within 6 months after licensure a Florida laws and rules course that is approved by the board. Once the department has received the results of the national criminal history check and has determined that the applicant has no criminal history, the appropriate license by endorsement shall be issued to the applicant.

- Canadian Registered Nurses who took the Canadian Nurses Association Testing Service (CNATS) Examination after August 8, 1995 must take the NCLEX Examination unless licensed in another U.S. state or territory. If test scores are in an acceptable range, Canadian Registered Nurse applicants who took the CNATS prior to August 8, 1995 may be eligible for endorsement. Unless licensed in another U.S. state or territory, Canadian Licensed Practical Nurses are required to apply by examination.

All sections must be completed in full. If an item does not apply, indicate with N/A. N/A is not an acceptable answer for "Yes" or "No" questions.

If you have questions that are not answered in this application packet, you can find answers to commonly asked questions on our website at: http://www.floridasnursing.gov/help-center/#faqs

Florida Board of Nursing
PO Box 6330
Tallahassee, FL 32314
Phone: (850) 245-4125
Fax: (850) 617-6460

Nursing Licensure by Endorsement Application

Website: www.floridasnursing.gov
Email: Mqa.NursingAppstatus@flhealth.gov

Please complete this application in its entirety prior to printing.

Do Not Write in this Space
For Revenue Receipting Only

Fees must be paid in the form of a cashier's check or money order, made payable to: DOH Florida Board of Nursing

Choose your application type:

☐ Registered Nurse (RN) 1701- $110.00

☐ Licensed Practical Nurse (LPN) 1702- $110.00

Total fee of $110.00 includes the following:

Processing Fee	$50.00
Initial Licensure Fee	$50.00
Student Loan Forgiveness Fund	$ 5.00
Unlicensed Activity Fee	$ 5.00

An applicant, who is denied licensure, or withdraws the application prior to licensure, is entitled to a refund of $60.00 (initial licensure, student loan forgiveness and unlicensed activity fees). A signed request to withdraw or for a refund must be made in writing. Fees are refundable for up to 3 years from the date of receipt.

1. PERSONAL INFORMATION

Name: ______________ ______________ ______________ **Date of Birth:** ______________
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (Give the address where mail and your license should be sent)

______________ ______________ ______________
Street/P.O. Box Apt. No. City

______________ ______________ ______________ ______________
State Zip Country Home/Cell Telephone **(Input with dashes)**

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

______________ ______________ ______________
Street Apt./Suite No. City

______________ ______________ ______________ ______________
State Zip Country Work/Cell Telephone **(Input with dashes)**

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☐ Female RACE: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other ______________

NAME ______________________________

Email Notification: If you want to be notified of the status of your application by email please check the "Yes" box and write your email address on the line provided below. If you choose this form of notification you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the Board office at: mqa.nursingappstatus@flhealth.gov

I want to be notified by email ☐ Yes ☐ No

Email Address: ______________________________

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. NURSING EDUCATION HISTORY

A. NURSING SCHOOL ATTENDED: ______________________________

Address: ______________________________

City: ____________ State: ________ Zip: ________ Country: ____________

B. Program Type: ☐ DIPL ☐ LPN ☐ ADN ☐ BSN C. Date Graduated ________ (MM/YYYY)

D. ADDITIONAL NURSING PROGRAM ATTENDED: ______________________________

E. Program Type: ☐ DIPL ☐ LPN ☐ ADN ☐ BSN F. Date Graduated ________ (MM/YYYY)

3. APPLICANT BACKGROUND **Attach additional sheets, if necessary**

A. List any other name(s) by which you have been known in the past. ______________________________

B. What name(s) did you use when you received your nursing education? ______________________________

C. What name did you use when you were first licensed? ______________________________

D. Have you ever applied for licensure by examination in Florida, as a ☐ RN ☐ LPN ? Date ________

E. Have you ever applied for licensure by endorsement in Florida, as a ☐ RN ☐ LPN ? Date ________

F. Have you ever been licensed in Florida as an ☐ RN ☐ LPN ? Date ________

G. ☐ Yes ☐ No * Have you ever been denied or is there now any proceeding to deny your application for any health care license to practice in Florida or any other state, jurisdiction or country?

*If you answer "Yes" to question G in this section you must submit a self explanation as to why you are answering "Yes" to this question.

NAME ______________________________

H. List all nursing licenses (**active, inactive or lapsed**). Submit a License Verification Form to your original and an active state of licensure (ATTACH ADDITIONAL SHEET, IF NECESSARY)

State/Country	License No.	RN or LPN	Date of Licensure	Status of License and Expiry Date

The Florida Board of Nursing requires verification of licensure from your original state of licensure (exam) and from a state where you have a current active license. Only (1) verification is required if your original state is current (active). **You may need to use one or both of the following methods to have your license verification sent to Florida.**

☐ Visit www.nursys.com and see if your state is listed. If your state(s) is listed register and pay the verification fee.

☐ Nursing License Verification Form: This form is for use with Non-NURSYS states and is found at the end of this application.

4. MANDATORY PREVENTION OF MEDICAL ERRORS REQUIREMENT

Completion of a two-hour course on the Prevention of Medical Errors is required prior to licensure. This course must be from an approved Florida Board of Nursing provider. Courses can be found online at www.CEbroker.com

☐ I have completed a 2 hour course on the Prevention of Medical Errors as required by Florida law.

* Applicants who check this box **do not need to** submit proof of completion.

☐ I have NOT completed a 2 hour course on the Prevention of Medical Errors as required by Florida law.

* Applicants who check this box **must subsequently submit** proof of completion.

5. CRIMINAL HISTORY

Answers to commonly asked questions can be found on our website at: http://www.floridasnursing.gov/help-center/#faqs

A. ☐ Yes ☐ No Have you **EVER** been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld**.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

B. Yes No Have you EVER had any records sealed pursuant to section 943.059, F.S., or other states applicable statute?

Failure to disclose information in this section may result in a denial of your application.

If you answered "Yes" to either of the questions above you are required to send the following items:

☐ **Self Explanation** describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain document from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Three (3) current (written within the last year) professional **Letters of Recommendation**.

NAME ______________________________

6. LIVESCAN PRIVACY STATEMENT

☐ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation. (Found in the forms following this application). The Board will not receive your Livescan results if you do not affirm the above statement by checking this box.

☐ **Electronic Fingerprinting**: **(Required for ALL applicants)**

All applicants, including out-of-state and out-of-country applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan device providers that are approved by the Florida Department of Law Enforcement. For a list of approved Livescan vendors, please visit our website at : http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html;

Typically background results submitted by Livescan are received by the Board within 24-72 hours of being processed. The Board of Nursing's ORI number is: ***EDOH4420Z***. **The Board cannot accept hard fingerprint cards or results**. All results must be submitted electronically by the Livescan service provider.

Livescan screenings done by a Florida Police or Sheriff's Department require that you login to the FDLE Civil Applicant Payment System (CAPS) at https://caps.fdle.state.fl.us and pay a fee before results will be released to our office.

Applicants who reside in an area where no Livescan service providers are available or because of state laws prohibiting transmission of fingerprints electronically across state lines should contact a Florida Livescan service provider who has the capability to convert a traditional card (hard card) into an electronic fingerprint card.

Because the Florida Department of Health retains fingerprints on any applicant who is required to undergo a criminal history screening as of January 1, 2013, those prints are retained in the Care Provider Clearinghouse. This Clearinghouse allows for the sharing of criminal history information among specified agencies.

One of the requirements for your Livescan to be retained in the Clearinghouse is a photograph taken by the Livescan service provider at time of fingerprinting. If your Livescan is completed without a photograph, you may have to undergo additional fingerprinting in the future.

Applicants needing hard fingerprint cards can request them via email at: Mqa.NursingAppstatus@flhealth.gov

- Please include your current mailing address in your request for fingerprint cards.
- **The Board cannot accept hard fingerprint cards or results.**

For Frequently Asked Questions about Livescan see our website at: http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html;

Livescan service providers that offer hard card conversion to electronic fingerprinting (Livescan):

- Biometric Information Management
  www.bioinfomgt.com
  Call: 614.791.3220
- Ideal Identification, Inc.
  http://www.idealid.net/
  Call: 866.288.6543
- Fieldprint
  https://florida.fieldprint.com/User/
  Call: 877-614-4364
- L-1 Solutions
  www.L1Enrollment.com
  Call: 888.859.4356 or 800.528.1358

NAME ____

7. DISCIPLINARY HISTORY

A. ☐ Yes ☐ No Have you ever had disciplinary action taken against your license to practice any health care related profession by the licensing authority in Florida or in any other state, jurisdiction or country?

B. ☐ Yes ☐ No Have you ever surrendered a license to practice any health care related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?

C. ☐ Yes ☐ No Do you have disciplinary action pending against any license?

Failure to disclose information in this section may result in a denial of your application.

If you answered "Yes" to any of the questions in this section, you are required to send the following items:

☐ **Self Explanation,** describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint and Final Order**.

☐ Three (3) current (written within the last year) professional **Letters of Recommendation**.

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8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony convictions fall into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "**Yes" to any of the following questions,** please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☐ No Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No"to the question above, skip to question 2.

a. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).

NAME ____________________________________

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "Yes", please provide supporting documentation).

2. ☐ Yes ☐ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before to the date of this application?

5. ☐ Yes ☐ No Are you currently listed on the United States Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals and Entities?

6. ☐ Yes ☐ No **If "Yes" to any of the questions 1 through 5 above**, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (**If "Yes", please provide official documentation verifying your enrollment status.**)

9.

Confidential and Exempt from Public Records Disclosure

* This page and the following page are exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USC § 666(a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by Section 456.013(1)(a), Florida Statutes.

Last Name: ______________________________

First Name: ______________________________

Middle Name: ______________________________

Social Security Number: ______________________________
(Input without dashes)

Social Security Information - * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at **www.ssa.gov** or by calling 1-800-772-1213.

Board of Nursing
4052 Bald Cypress Way, Bin # C02
Tallahassee, Florida 32399-3252
Phone: (850) 245-4125 Fax: (850) 617-6460
Website: www.floridasnursing.gov

NAME ____

10. EXAMINATION HISTORY

A. ☐ Yes ☐ No Have you ever taken an examination for RN or LPN licensure?

B. If "Yes", list the **jurisdiction (state/territory) for which the examination was taken and passed.**

Examination	State/Country	Month/Year	Results
☐ RN ☐ PN	____________	____________	☐ Pass ☐ Fail
☐ RN ☐ PN	____________	____________	☐ Pass ☐ Fail
☐ RN ☐ PN	____________	____________	☐ Pass ☐ Fail
☐ RN ☐ PN	____________	____________	☐ Pass ☐ Fail

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11. HEALTH HISTORY **(Supporting documentation should be sent directly to the Board Office)**

A. ☐ Yes ☐ No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

B. ☐ Yes ☐ No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

C. ☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice nursing within the past five years?

D. ☐ Yes ☐ No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

E. Yes No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice nursing within the past five years?

If you answered "Yes" to any of the questions in this section , you are required to send the following items:

Self Explanation, explaining the medical condition(s) or occurrence(s) and current status.

Letter(s) from Licensed Professional summarizing diagnosis, treatment and prognosis; or any other official documentation as it relates to any "Yes" answer. **Documentation must be current within the last year.**

NAME ____

12. ADDITIONAL INFORMATION

Availability for Disaster: ☐ Yes ☐ No

Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

____

Florida Center for Nursing:

The Florida Center for Nursing is the definitive source for information, research, and strategies addressing the dynamic nurse workforce needs in Florida. The Center conducts multiple annual and biennial research projects, including nurse employer and nursing program surveys, to provide a comprehensive look at Florida's nurse population.

Based on this research, the Center projects a severe nursing shortage in Florida – a shortage that could have a devastating impact on health care quality and access for Florida's residents. The Florida Center for Nursing also uses the research it produces to address issues of supply and demand and utilization of scarce nurse workforce resources throughout the state.

In addition to nurse workforce research, the Florida Center for Nursing aims to improve the retention and recruitment of nurses in Florida through funding small grants and also by collecting and disseminating information on best practices and innovative strategies for nurse retention and recruitment. Increasing production of new nurses alone will not resolve the shortage. Efforts must be taken to retain the experiential knowledge of our existing nurses.

To learn more about Florida's nursing shortage and suggested solutions, for more information about the Center, and to understand how your contribution will be put to work, please visit the Center's website at:
http://www.flcenterfornursing.org/Donations/HowyourdonationshelptheFCN.aspx

The Florida Center for Nursing's operating revenues are derived in part from your donation. In order for the Florida Center for Nursing to continue its work on behalf of nurses, please donate by going to their website or by adding your donation with your application fee.

Do you want to donate to the Florida Center for Nursing? ☐ Yes ☐ No

If you chose to include a donation with your application fee please indicate the amount. $_______________

Donations are voluntary and do not impact the processing of your application.Donations made through the Florida Center for Nursing's website are tax deductible.

NAME ____

13. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the State of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083 and 775.084, Florida Statutes.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Registered Nurse or Licensed Practical Nurse in the State of Florida.

I further state that I have read and understand Chapter 464, Florida Statutes, and Rule Chapter 64B9, Florida Administrative Code as they pertain to the practice of nursing (Note: A current copy of Ch 464 and Rule Chapter 64B9 may be obtained via the internet at http://www.floridasnursing.gov).

Florida Law requires you to immediately inform the Board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I will comply with all requirements for licensure renewal including continuing education credits.

Applicant's Signature____ **Date** ________________

This field cannot be typed. You must print out the application and sign it. MM/DD/YYYY

All applications filed with the department are valid for one (1) year from the date of receipt.

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html;
- Livescan screenings done by a Florida Police or Sheriff's Department require that you login to the FDLE Civil Applicant Payment System (CAPS) at https://caps.fdle.state.fl.us and pay a fee before results will be released to our office.
- Out of State/Country Livescan directions are included in the electronic fingerprinting section of this application.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Nursing is: ***EDOH4420Z***.
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: ______________________________

Aliases: ______________________________

Date of Birth: ____________ (MM/DD/YYYY) Place of Birth: ____________

Social Security Number: ____________

Citizenship: ____________ Race: ______ (W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: ______ (M=Male; F=Female) Weight: ______ Height: ______

Eye Color: ______ Hair Color: ____________

Address: ______________________ Apt. Number: ______

City: ____________ State: ______ Zip Code: ______

Transaction Control Number (TCN#): ______________________
(This will be provided to you by the Live Scan Vendor.)

You will need to keep this form for your records. Do not send this form to the Board Office.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Y**our Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.**
Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub. L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as my be relevant to the activity for which this application is being submitted, the FBI(may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Complete verifications must be mailed, or sent electronically, directly from the verifying agency to:

Florida Board of Nursing
4052 Bald Cypress Way
Bin # C02
Tallahassee, FL 32399-3252

Florida Board of Nursing
License Verification Request

Who needs to use this form?

- Applicants whose state(s) do not participate in the Nursys system should use this form.
  - * All applicants are required to provide verification of their initial license and an active license.
  - * A large number of states verify licensure using the Nursys system. Applicants should check and see if their state participates in the Nursys system by logging on to www.nursys.com.
  - * Verification must be sent directly to our office by the verifying agency. **Copies of licenses and website screen shots do not meet the requirement for verification of licensure.**
  - * You are responsible for fees incurred for verification of your licensure.

PART I: TO BE COMPLETED BY APPLICANT (Send to your original and current state(s) of licensure. *No verification is required for previous Florida licenses.* Make copies as necessary.)

Applicant Name: ______________________________ SSN: ________________

Address: ____

Name original license was issued under: ______________________________

License Number: ________________________ State of: ________________

I hereby authorize release of any information regarding my licensure status to the Florida Board of Nursing.

Applicant Signature: ______________________________ Date: ____________

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PART II: TO BE COMPLETED BY YOUR STATE BOARD OF NURSING

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official Board seal
* Signature and title of state Board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Level of licensure (RN/LPN)
* Dates of issuance/expiration
* Licensure method (state exam, national exam, endorsement, reciprocity)
* Has this license ever been encumbered (denied, revoked, suspended surrendered, limited, placed on probation)?
* If this license has ever been encumbered please forward all orders to the Florida Board of Nursing with this form.

Complete verifications must be mailed directly from the verifying agency to:

Florida Board of Nursing
4052 Bald Cypress Way
Bin # C02
Tallahassee, FL 32399-3252

Florida Board of Nursing
Employment Verification Request

Who needs to use this form?

- Applicants who have not taken the NCLEX, but have practiced in a U.S. State or Territory must show proof of work in a U.S. State or Territory for two (2) of the last three (3) years at the level (Licensed Practical Nurse/ Registered Nurse) of licensure as it relates to your application type.
- Applicants who have taken the SBTPE or NCLEX but do not have an ACTIVE license, and who have worked in the previous 5 years, must complete this form.
- Applicants who have taken the SBTPE or NCLEX and have an ACTIVE license DO NOT need to complete this form.

PART I: To be completed by applicant- Complete this part and submit a copy to each place you were employed during the last three years.

Applicant Name: ________________________________ SSN:____________________

Address: ____

Name of hospital or agency: ____

I hereby authorize release of any information regarding my employment status with your facility to the Florida Board of Nursing.

Applicant Signature: ____ Date: ________________

PART II: To be completed by employer- All verifications must be in English and mailed directly from the hospital personnel office or agency/employer and must include the following criteria:

*** Typed on official agency letterhead with an original signature**
* Applicant Name
* Applicants Social Security number
* Indicate level of licensure while employed (Registered Nurse/Licensed Practical Nurse)
* Position title while employed
* Place of employment
* Address of employer to include: mailing address, city, state and zip code
* Employer's telephone number to include: area code and number
* Start and End dates of employment (month and year)
* Eligible for rehire? (Yes/No) If not eligible for rehire, please provide written details.
* Printed name of verifying agent
* Signature of verifying agent and date completed

DH-MQA 1095, 08/14, Rule 64B9-3.008 FAC