

Nursing Multi-State License Upgrade Application



**Board of Nursing
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasnursing.gov
Email: Mqa.Nursingappstatus@flhealth.gov
Phone: (850) 245-4125
Fax: (850) 617-6460**



Important Information for all Applicants

To apply for a multistate license upgrade **you must have a current single state Florida** Licensed Practical Nurse (LPN) or Registered Nurse (RN) license. If your declared primary state of residency is another Compact State, you are not eligible for a multistate license in Florida.

Nurse Licensure Compact State Information

Florida is a member of the Nurse Licensure Compact (NLC). The NLC allows a registered nurse or licensed practical nurse licensed in a Compact State to practice across state lines in another Compact State without having to obtain a license in the other state unless the nurse moves and declares the new Compact State as their new primary state of residence. It is important to understand that the NLC requires nurses to adhere to the nursing practice laws and rules of the state in which they practice under their Compact license. The Compact does not include Advanced Practice Registered Nurses. If a nurse moves from one state to another and establishes residency, the nurse must apply for licensure in that state. Visit the National Council of State Boards of Nursing (NCSBN) website <https://www.ncsbn.org/nurse-licensure-compact.htm> for a list of states that have implemented the Compact.



Multistate License Upgrade Application

Board of Nursing
P.O. Box 6330
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Fax: 850-617-6460
Email: mqa.nursingappstatus@flhealth.gov

Do Not Write in this Space
For Revenue Receiving Only

Applicants must have a current Florida LPN or RN license that is not expiring within 120 days of applying for this upgrade. If your license will expire within 120 days, you will need to renew prior to applying for the upgrade. Visit www.flhealthsource.gov to renew your license.

<p>Florida License Number: _____</p> <p>Select License to Upgrade:</p> <p><input type="checkbox"/> Registered Nurse (RN) 1701- \$100.00</p> <p><input type="checkbox"/> Licensed Practical Nurse (LPN) 1702- \$100.00</p>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>Total fee of \$100.00 includes the following:</p> <table style="width: 100%;"> <tr> <td>Processing Fee (non-refundable)</td> <td style="text-align: right;">\$50.00</td> </tr> <tr> <td>Initial Licensure Fee</td> <td style="text-align: right;">\$50.00</td> </tr> </table> </div> <p>Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a \$50.00 (Initial Licensure Fee) refund. Fees are refundable for up to three years from the date of receipt. Requests for withdrawal and/or refund must be made in writing.</p>	Processing Fee (non-refundable)	\$50.00	Initial Licensure Fee	\$50.00
Processing Fee (non-refundable)	\$50.00				
Initial Licensure Fee	\$50.00				

1. PERSONAL INFORMATION

Name: _____			Date of Birth: _____	
Last/Surname	First	Middle	MM/DD/YYYY	
_____ Street/P.O. Box		Apt. No.	City	
_____ State	_____ ZIP	_____ Country	_____ Home/Cell Telephone (Input without 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. No.	City	
_____ State	_____ ZIP	_____ Country	_____ Work/Cell Telephone (Input without dashes)	

Email Notification: To be notified of the status of your application by email check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email 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. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, s. 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

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, § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. 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 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 C-02
Tallahassee, FL 32399-3252

Name: _____

3. NURSE LICENSURE COMPACT (NLC)

Requirements that must be met in order to qualify for a multistate license from Florida:

Florida must be the Primary State of Residence*
Must have passed the NCLEX or the SBTPE
Florida's requirements for initial licensure must be met
License status must be clear and unencumbered**
Must not have a felony conviction***, regardless of adjudication
Must not be enrolled with the Intervention Project for Nurses (IPN) or any other treatment program for impaired practitioners
Must have a U.S. Social Security number

Terminology:

***Primary state of residence** is defined by the Compact as the "person's declared fixed permanent and principal home for legal purposes; domicile."

****Encumbrance** means "revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing, imposed by a licensing board."

*****Felony conviction** is defined as being "convicted or found guilty, or has entered into an agreed disposition other than a disposition that results in nolle prosequi, for a felony offense under applicable state or federal criminal law."

Proof of primary residence may include but is not limited to:

Driver license with a home address
Voter registration card displaying a home address
Federal income tax return declaring the primary state of residence
W2 from U.S. Government or any bureau, division, or agency thereof indicating the declared state of residence

A. Do you declare Florida to be your primary state of residence and are you providing a Florida address?
 Yes No

If you **do not have a current Florida mailing address, and wish to have a multistate license, you must provide** one of the documents listed above. If Florida is not your primary state of residence, you are **not eligible** for a Florida multistate license.

B. Do you hold an active NLC multistate license in another state? Yes No

A nurse may only hold one multistate license. If your declared primary state of residence is another Compact state and you are not changing your primary residence to Florida, you are **not eligible** for a multistate license in Florida and should **not submit this application**, as your NLC license allows you to practice in Florida.

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

Name: _____

This information is exempt from public records disclosure

5. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

- A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No
- B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

- C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No
- D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No
- E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

- A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.
- A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status

For Multistate Applicants ONLY:

Are you a current participant in an alternative to discipline program [i.e. Intervention Project for Nurses (IPN)]?

- Yes No

Documentation for this section must be sent to the board office at MQA.Nursing@flhealth.gov or mailed to:

Board of Nursing
4052 Bald Cypress Way Bin C-02
Tallahassee, FL 32399-3252

Name: _____

6. CRIMINAL HISTORY

- A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any 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 (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

- B. Have you ever had any records sealed pursuant to s. 943.059, F.S., or other state's applicable statute?
 Yes No

If you responded "Yes" in this section, complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N

If you responded "Yes," you must provide the following:

- Self-Explanation**, describing in detail the circumstances surrounding each offense; including date, 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 documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.
- Three current (*written within the last year*) professional **Letters of Recommendation**.

7. 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 s. 456.0635(2), F.S.

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

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

- a. 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? Yes No
- b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation? (This question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.). Yes No
- c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No
- d. 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," provide supporting documentation).
 Yes No

Name: _____

2. 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)? Yes No

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

- a. 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? Yes No
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? Yes No

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

- a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

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

- a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No
- b. Did termination occur at least 20 years before the date of this application? Yes No
5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No
- a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No
- b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

- 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.
- Supporting documentation** including court dispositions or agency orders where applicable.

Documentation for section 6 and 7 must be sent to the Background Screening Unit at MQA.BackgroundScreen@flhealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

Name: _____

8. 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 confirm the above statement by checking the box.

Electronic Fingerprinting: (Required for ALL applicants)

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: <http://www.flhealthsource.gov/background-screening/>.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board'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 performed 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 your results will be released to our office.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. You will be notified when your retention date is approaching and will be provided with instructions on how to retain your fingerprints to avoid having to submit a new background screening.

Applicants needing hard fingerprint cards can request them via email at MQA.BackgroundScreen@flhealth.gov. Request must include the current mailing address you want the cards mailed to. To find providers who offer this service go to <http://www.flhealthsource.gov/bgs-providers>. Click on "Out of State/International" section of the map.

9. 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 pursuant to s. 456.072, F.S., or criminal penalties pursuant to s. 456.067, F.S.

I further state that I have read and understand ch. 464, F.S., and Rule ch. 64B9, Florida Administrative Code (F.A.C.) as they pertain to the practice of nursing (Note: A current copy of ch. 464 and rule ch. 64B9 may be obtained online at <http://www.floridasnursing.gov>).

Florida law requires me 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.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS 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 to be employed, licensed, work under contract, or 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 Person 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.

Your 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 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 your 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.

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 may 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, disclosure 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 a 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 additional information 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.

Board of Nursing Electronic Fingerprinting



Take this form with you to the Livescan service provider. 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 a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: <http://www.flhealthsource.gov/background-screening/>.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- 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: _____ SSN#: _____

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

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

Sex: - _____
(M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.