



MAINE STATE BOARD OF NURSING

158 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA, MAINE 04333-0158
(207) 287-1138

APPLICATION FOR LICENSE AS A CERTIFIED REGISTERED NURSE ANESTHETIST

DO NOT WRITE IN THIS SPACE

Application Received _____

Application Approved by Board of Nursing: _____

Fee: CC Cash Check MO _____

Chair

License Date _____

Executive Director

LICENSE NUMBER _____

Date

INSTRUCTIONS An applicant must submit to the Board of Nursing office the following:

1. Application form completed in **ink or typewritten**, with signature in applicant's handwriting;
2. Fee of \$100.00 in the form of Visa/MasterCard/Discover Card (credit card form enclosed), check or money order in U.S. funds, made payable to "Treasurer of the State of Maine";
3. Recent passport type photograph (2 x 2 and no more than two years old) enclosed with the application form;
4. Verification of authority to test directly from your certifying body (N/A if already certified);
5. Receipt verifying your scheduled exam date (N/A if already certified); Verification of
6. Final transcript(s) with degree(s) conferred directly from your Advanced Practice Registered Nurse program (if you have completed both a master's and postmaster's degree program, the office will need both transcripts).
7. A criminal background check (CBC) must be completed through the Maine Department of Public Safety (DPS) and the FBI based on a set of fingerprints provided to. Register for fingerprinting online at <https://me.ibtfingerprint.com/>. If you do not register you will not be able to have your fingerprints taken. There is a one-time \$52 fee for this process.

FOR APPLICANTS WHO LEGALLY RESIDE IN ANOTHER COMPACT STATE AND HOLD A COMPACT LICENSE IN THAT STATE, the following items are required:

1. Complete verification of basic nurse nursing licensure from the original state of licensure (either through NURSUS at www.nursus.com if the state participated in NURSUS for nursing verification or request a paper verification from nonparticipating NURSUS states; and
2. Complete a basic nursing information form (enclosed).

YOU MAY NOT PRACTICE NURSING IN MAINE UNTIL YOU RECEIVE AUTHORIZATION FROM THIS OFFICE

THE APPLICATION FEE IS NOT REFUNDABLE

SECTION 1. PROFILE INFORMATION

| | | | | |
|--|------------------------------|-------------------------------|-----------------------------------|-------|
| FULL LEGAL NAME | FIRST | FULL MIDDLE OR "N/A" | MAIDEN | LAST |
| ANY OTHER NAMES EVER USED | | | | |
| DATE OF BIRTH | PLACE OF BIRTH | | CITY | STATE |
| SOCIAL SECURITY NUMBER | | PERSONAL EMAIL ADDRESS | | |
| MAILING ADDRESS *This is considered your public contact address | | | | |
| CITY | STATE | ZIP CODE | COUNTRY | |
| RESIDENTIAL ADDRESS (if different from above) | | | | |
| PHONE NUMBER(S) | HOME | MOBILE | BUSINESS | |
| HIGH SCHOOL | NAME | LOCATION | DATE OF GRADUATION / / | |
| G.E.D. | <input type="checkbox"/> YES | <input type="checkbox"/> NO | DATE OF G.E.D. DIPLOMA / / | |

SECTION II. DISCIPLINARY INFORMATION

PLEASE READ AND ANSWER EACH QUESTION CAREFULLY AND TRUTHFULLY:

NOTE: Answers found to be fraudulent may result in denial, fines, suspension, and/or revocation of a license.

- A. Has any licensing authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license, certificate or multi-state privilege held by you now or previously, or ever fined, censured, reprimanded, or otherwise disciplined you? YES NO
- B. Is there any complaint pending against your license in any state or jurisdiction including Canadian and foreign jurisdictions? YES NO
- C. Have you ever been disciplined for problems resulting from a physical illness or condition? YES NO
- D. Have you ever been disciplined for problems resulting from mental illness? YES NO
- E. Are you currently participating in a substance abuse and/or alcohol or drug treatment program or have been diagnosed with a substance abuse disorder which in any way currently affects or limits your ability to practice safely and in a competent and professional manner? YES NO
- F. Have you ever been disciplined for problems resulting from chemical dependency? YES NO
- G. For any criminal offense, including those pending appeal, have you: *(please select below all that apply)* YES NO
 - a. Been convicted of a misdemeanor?
 - b. Been convicted of a felony?
 - c. Pled nolo contendere, no contest, or guilty?
 - d. Received deferred adjudication?
 - e. Been placed on community supervision or court-ordered probation, whether or not adjudicated guilty?
 - f. Been sentenced to serve jail or prison time? Court ordered confinement?
 - g. Been granted pre-trial diversion?
 - h. Been arrested or have any pending criminal charges?
 - i. Been cited or charged with any violation of the law? *(other than parking tickets and/or traffic violations)*
 - j. Been subject of a court-martial; Article 15 violation; or received any form of military judgement/punishment/action?
- H. Are you currently the target or subject of a grand jury or government agency investigation? YES NO

NOTE: If you answered "YES" to questions A-G listed above, attach a letter of explanation that is dated and signed indicating the circumstances you are reporting to the Board. If you answered "YES" to questions G or H, you must also attach the document(s) showing the disposition of the case(s).

SECTION III. ADVANCED PRACTICE NURSING EDUCATION

| | |
|--|--------------------|
| SCHOOL OF PROFESSIONAL NURSING | NAME |
| ADDRESS | |
| DATE OF ENTRANCE | DATE OF GRADUATION |
| / / | / / |
| ACCREDITING AGENCY OF APRN PROGRAM (E.G. COA) | |
| Certificate <input type="checkbox"/> Baccalaureate <input type="checkbox"/> Masters <input type="checkbox"/> Doctoral <input type="checkbox"/> Post Masters <input type="checkbox"/> | |

SECTION IV. LICENSURE HISTORY

Do you hold, or have you ever held a license to practice nursing (Registered Professional – RN) in the State of Maine? YES NO

If you have been issued an RN license, please enter: License Number: _____ Expiration Date: ____/____/____

SECTION V. EMPLOYMENT INFORMATION

A. List employment in nursing for the past five years.

| Name of Agency | City and State | Dates of Employment | |
|----------------|----------------|---------------------|--------|
| | | FROM / / | TO / / |
| | | FROM / / | TO / / |
| | | FROM / / | TO / / |

B. If you **have not** been employed in nursing in the last five years, please explain. _____

C. Are you currently employed as a Nurse Anesthetist? YES NO

If yes, please specify: NAME ADDRESS PHONE NUMBER

D. Where in Maine do you plan to work?

NAME ADDRESS PHONE NUMBER

SECTION VI. NURSE ANESTHETIST CERTIFICATION

Are you currently as a Nurse Anesthetist by a national certifying body?

If YES indicate the specialty(ies), certifying body(ies), certification number(s), and expiration date(s): _____

If NO indicate name of qualifying examination(s) and date(s) scheduled to test: _____

SECTION VIII. DECLARATION OF PRIMARY RESIDENCE

A. I declare that the State of _____ (state)** is my primary state of residence as of ____/____/____ (date) and that such constitutes my permanent and principal home for legal purposes. ("Primary state of residence" is defined as the state of a persons declared fixed permanent and principal home for legal purposed; domicile.)

B. Upon licensure in Maine, in which state(s) do you intend to practice?

C. Are you currently employed in the U.S. Military (Active Duty) or in the U.S. Federal Government? YES NO

TAPE TOP ONLY

One recent photograph

Photo must be:

Full face view

Passport Type

← 2 x 2 only →

Clear and recognizable likeness

By my signature, I the undersigned, being duly sworn, say that I am the person referred to in this application for licensure in the State of Maine and hereby certify that the information provided on this application is true and accurate. By submitting this application, I affirm that I have complied with all requirements of the law, and that I have read and understand this affidavit and that the Maine State Board of Nursing will rely on this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension, or revocation of my license if this information is found to be false.

Signature of Applicant _____ Date _____

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRSA §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers, and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website. The mailing address is considered your public contact address.



MAINE STATE BOARD OF NURSING

158 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA, MAINE 04333-0158
(207) 287-1138

BASIC NURSING INFORMATION FORM

To be completed by an Advanced Practice Registered Nurse who legally resides in, and holds a multistate license, in another compact state and has never been issued a Maine Registered Professional Nursing license.

Applicants Name: _____
(First) (Middle) (Last)

1. BASIC NURSING EDUCATION *(First Registered Nurse Program You Completed)*

School of Professional Nurse: _____

**If foreign prepared, transcript is required*

School Address: _____

Date of Entrance: _____ Date of Graduation: _____ Length of Program*: _____

**If program is less than 2 years, please give details (i.e. If you have a previous degree):* _____

Diploma Associate Baccalaureate Masters Doctoral Certificate

2. LICENSURE HISTORY *(Original Registration)*

State/Country: _____ Year: _____ License Number: _____

If license in another country, what U.S. State were you originally licensed in?

State/Country: _____ License Number: _____

Verification of licensure is required from original U.S. state jurisdiction and country (if applicable) via NURSYS at www.nursys.com (NURSYS verification participating state) or paper document directly from country and/or state (non-participating NURSYS state).



MAINE STATE BOARD OF NURSING

158 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA, MAINE 04333-0158
(207) 287-1138

CREDIT CARD AUTHORIZATION FORM

Please Provide the Following:

We accept Visa/MasterCard/Discover Card

Credit Card # _____

Credit Card Expiration Date:
(mm/yy) _____

Your Name
(if not the Card Holder) _____

Card Holder's Name:
(as it appears on the Card) _____

**Card Holder's Billing
Address** _____

Card Holder's Signature _____