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 NURSE PRACTITIONER

DO NOT WRITE IN THIS SPACE

Application Received _____

Fee: ☐ CC ☐ Cash ☐ Check ☐ MO _____

License Date _____

LICENSE NUMBER _____

Application Approved by Board of Nursing:

_____
Chair

_____
Executive Director

_____
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*" (if adding more than one specialty to this license, a fee of $50.00 per additional specially is required);
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);
6. Verification of certification as a nurse practitioner directly from your certifying body (other than ANCC, AACN, PNCB, and NCC);
7. Registration of supervision with a licensed physician or nurse practitioner in the same practice category as the applicant (requirement is 24 months of supervision based on a full time work week – form enclosed. IF YOU HAVE MET THIS REQUIREMENT IN ANOTHER JURISDICTION PLEASE SUBMIT A LETTER SIGNED FROM YOUR SUPERVISOR; and
8. 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).
9. A criminal background check (CBC) must be completed through the Maine Department of Public of 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 NURSYS at www.nursys.com if the state participated in NURSYS for nursing verification or request a paper verification from nonparticipating NURSYS 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. ☐ YES ☐ 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 contender, 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 II1. ADVANCED PRACTICE NURSING EDUCATION

SCHOOL OF PROFESSIONAL NURSING	NAME
	ADDRESS
DATE OF ENTRANCE / /	DATE OF GRADUATION / /
ACCREDITING AGENCY OF APRN PROGRAM (E.G. NLNAC OR CCNE)	

Certificate ☐ Baccalaureate ☐ Masters ☐ Doctoral ☐ Post Masters ☐

List Nurse Practitioner specialty(ies) you are requesting to add as part of your Nurse Practitioner license:

(e.g. Adult Health, Adult Psych, Mental Health) _____ _____ _____

_____ _____ _____

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: _____ and 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 as a Nurse Practitioner in the last five years, please explain. _____

C. Are you currently employed as a Nurse Practitioner? ☐ **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 PRACTITIONER CERTIFICATION

Are you currently certified in any specialty(ies) as a Nurse Practitioner by a national certifying body? (e.g. Adult Health, Psychiatric Mental Health)

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 VII. PHARMACOLOGY & PRESCRIPTIVE PRACTICE

A. Did you have a course in pharmacology in your nurse practitioner program? ☐ **YES** ☐ **NO**

IF YES, how many credits and/or contact house? _____ (45 contact hours/3 credits required)

IF NO, *but pharmacology was integrated*, please have your program send a letter explaining how integration was accomplished and how much pharmacology was included. Please have your program include information regarding the following in its explanation:

1. Number of contact hours and/or credits (45 contact hours/3 credits required)
2. Applicable state and federal laws
3. Prescriptive writing
4. Drug selection, dosage, and route
5. Information resources
6. Clinical application of pharmacology related to specific scope of practice

IF NO, *but you have obtained contact hours or credits in pharmacology in a formal academic setting or non-credit continuing education offerings*, please provide certificated and documents that verify the offering covered in the information numbers 1-6 or have your program send official transcripts **directly** to the Board.

B. Have you prescribed in the last two years? ☐ **YES** ☐ **NO** ☐ **New NP Graduate** _____

IF YES, please provide documentation from your current/former employer that you prescribed medications in the last two years.

IF NO, please provide the Board with documentation of 15 contact hours of recent (within the last two years) continuing education in pharmacology.

Have you prescribed in the last five years? ☐ **YES** ☐ **NO** ☐ **N/A**

IF NO, please provide the Board with documentation of 45 contact hours (3 credits) or recent (within the last two years) continuing education in pharmacology.

SECTION VII. 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.

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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).

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APPLICATION FOR APPROVAL OF A SUPERVISING RELATIONSHIP WITH A LICENSED PHYSICIAN OR NURSE PRACTITIONER

A Certified Nurse Practitioner who qualifies as an Advance Practice Registered Nurse must practice, for at least 24 months, under the supervision of a licensed Physician or a *supervising Nurse Practitioner or must be employed by a clinic or hospital that has a Medical Director who is a license Physician. The Certified Nurse Practitioner shall submit written evidence to the board upon completion of the required clinical experience (32 M.R.S.A. §2012 (2)(A)).

INSTRUCTIONS

1. **Before the new Nurse Practitioner (NP) begins employment,** the NP must register a supervising relationship with the Board as part of the Authorization To Practice process.
2. **When modifying a supervisory relationship,** the NP must register the change on the provided form within 15 days of beginning employment. A $50.00 late registration fee will be assessed if this form is not filed within 15 days of beginning employment.
3. **In the absence of** the Primary Supervising Physician or Nurse Practitioner, a Secondary Supervising Physician or Nurse Practitioner must be designated. This information must be included on the application.
4. **When a supervisory relationship is terminated,** the NP must notify the Board. The NP may use this form.
5. **At the end of the required twenty four months of supervision,** the NP must submit documentation of completion of the required clinical experience.

***NURSE PRACTITIONER SUPERVISORS:** The Nurse Practitioner must submit documentation to the Board of the following:

1. Completed 24 months of supervised practice;
2. Practiced as an Advanced Practice Registered Nurse for minimum of 5 years in the same specialty; and
3. Worked in a clinical health care field for a minimum of 10 years.

Please Type or Print All Information Clearly *(attach a separate page if more space needed)*

Name of Nurse Practitioner Applicant | **Maine License Number**

Nurse Practitioner Applicant Mailing Address

Primary Supervising Physician/Nurse Practitioner | **Maine License Number**

Secondary Supervising Physician/ Nurse Practitioner | **Maine License Number**

Secondary Supervising Physician/ Nurse Practitioner | **Maine License Number**

REGISTRATION FEE $50.00

You must submit a check or money order payable to the *"Treasurer State of Maine"* or complete the enclosed Credit Card Authorization Form.

Attach letter of supervision (synopsis of the services you will be providing) signed and dated by a licensed Physician or Nurse Practitioner in the same practice category and all secondary supervisors participating in this process.

1. Name(s)/Address(s) of Practice Setting(s)
*(**Start** date and hours per week **must be completed.** IF the start date if pending, please indicate that)*

Practice Type
(Please select one)

☐ Office Practice
☐ Clinic
☐ Hospital (Department) _____
☐ Other (Explain) _____

Tel: _____

Start Date: _____ Hours per Week: _____

2. Name(s)/Address(s) of Practice Setting(s)
*(Start date and hours per week **must be completed.** IF the start date if pending, please indicate that)*

Practice Type
(Please select one)

☐ Office Practice
☐ Clinic
☐ Hospital (Department) _____
☐ Other (Explain) _____

Tel: _____

Start Date: _____ Hours per Week: _____

3. Name(s)/Address(s) of Practice Setting(s)
*(Start date and hours per week **must be completed.** IF the start date if pending, please indicate that)*

Practice Type
(Please select one)

☐ Office Practice
☐ Clinic
☐ Hospital (Department) _____
☐ Other (Explain) _____

Tel: _____

Start Date: _____ Hours per Week: _____

Check appropriate box if supervisory relationship has ended.

☐ Termination of a Primary Supervising Relationship during the twenty-four-month supervisory period.

Please attach a letter signed by the Primary Supervising Physician or Nurse Practitioner indicating the time frame (beginning and end dates) and hours per week or total hours of supervision.

Name of Primary Supervising Physician or Nurse Practitioner:

_____

Effective Date: _____

Reason for Termination: _____

_____

_____

☐ Completion of the required twenty four month supervision requirement.

Please attach a letter signed by the Primary Supervising Physician or Nurse Practitioner indicating the time frame (beginning and end dates) and hours per week or total hours of supervision.

_____ _____

Signature of Applicant **Date**

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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 _____