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** **1 2**	**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 (including, but not limited to, the Maine State Board of Nursing) 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, but not limited to, Maine and Canadian and foreign jurisdictions? **YES** **NO**

C. Is there **any** complaint pending against your license in any state or jurisdiction, including, but not limited to, Maine and Canadian and foreign jurisdictions? **YES** **NO**

' Have you ever been disciplined for problems resulting from mental illness? **YES** **NO**

(. Are you currently participating in a substance abuse and/or alcohol or drug treatment program or have been diagnosed ZLWK D VXEVWDQFH DEXVH GLVRUGHU ZKLFK LQ DQ\ ZD\ FXUUHQWO\ DIIHFWV RU OLP FRPSHWHQW DQG SURIHVVLRQDO PDQQHU" **YES** **NO**

). Have you ever been disciplined for problems resulting from chemical dependency? **YES** **NO**

***** 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 **cite G Rh**U rged 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 <u>also</u> attach the document(s) showing the disposition of the case(s).

SECTION III BASIC NURSING EDUCATION (First Registered Nurse Program)

SCHOOL OF PROFESSIONAL NURSING NAME		
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 ☐

SECTION IV. LICENSURE HISTORY

ORIGINAL REGISTRATION:	**YEAR**	**LICENSE NUMBER**	**BY EXAM**
STATE			☐ **YES** ☐ **NO**
COUNTRY ***if applicable***			☐ **YES** ☐ **NO**

Have you completed a program preparing nurse practitioners, nurse anesthetists, nurse mid-wives, or clinical nurse specialists? ☐ **YES** ☐ **NO**

Do you plan to apply for licensure as an Advance Practice Registered Nurse? ☐ **YES** ☐ **NO**

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 in nursing? ☐ YES ☐ NO

If yes, please specify: NAME ADDRESS PHONE NUMBER

D. **Where do you plan to work? NAME ADDRESS PHONE NUMBER**

SECTION VI. 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

VERIFICATION OF REGISTERED PROFESSIONAL NURSE LICENSURE

To _____ **Board of Nursing**

Name of Applicant _____

Present Address _____

_____

License Number _____ **Date of Birth** ___/___/___ **Social Security Number** ___-___-_____

INFORMATION BELOW TO BE COMPLETED BY THE BOARD OF NURSING IN YOUR STATE OF ORIGINAL LICENSURE

EDUCATION

High School Diploma: ☐ YES ☐ NO ☐ G.E.D.

Nursing Program: State Accredited? ☐ YES ☐ NO Type: ☐ Associate Degree ☐ Baccalaureate Degree ☐ Diploma

Name of Nursing Program _____

Address _____

Date of Entrance ___/___/___ Date of Graduation ___/___/___ Length of Program _____

LICENSURE

License Number _____ Date Issued ___/___/___ Expiration Date of Current License ___/___/___

Issued by: ☐ Exam ☐ Endorsement ☐ Waiver

Has license ever been suspended, revoked, probated, reprimanded, or limited/restricted? ☐ YES (please attach explanation) ☐ No

EXAMINATION

Results of State Board Test Pool Examination/NCLEX (please indicate if exam was taken more than one time) Series Number:

Scores: *if applicant did not write SBTPE/NCLEX, specify type of test and list subjects and grades on back

Medical Nursing	_____	Psychiatric Nursing	_____
Obstetric Nursing	_____	Surgical Nursing	_____
Nursing of Children	_____	Comprehensive NCLEX	_____

Canadian Exams: ☐ CNATS ☐ Provincial Taken in: ☐ English ☐ French

NAME & TITLE

_____

(SEAL)

STATE

_____

DATE

_____

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:
(asit appears on the Card) _____

Card Holder's Billing Address _____

_____

_____

Card Holder's Signature _____