



# MAINE STATE BOARD OF NURSING

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

## APPLICATION FOR LICENSE AS A REGISTERED PROFESSIONAL NURSE BY ENDORSEMENT

**DO NOT WRITE IN THIS SPACE**

Application Received \_\_\_\_\_

Application Approved by Board of Nursing:

Fee:  CC  Cash  Check  MO \_\_\_\_\_

License Date \_\_\_\_\_

\_\_\_\_\_ Chair

\_\_\_\_\_ Executive Director

LICENSE NUMBER \_\_\_\_\_

\_\_\_\_\_ Date

**INSTRUCTIONS** An applicant for licensure by endorsement 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 \$75.00 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 licensure from your original state of Registered Professional Nurse licensure through NURSYS at [www.nursys.com](http://www.nursys.com) (\$30.00 Visa or MasterCard). Some states do not participate in the NURSYS verification. Please check with your state, if the state is not participating in NURSYS, please use the enclosed Maine verification form to send to your original state of licensure;
5. Additional verifications are also required if you have practiced in Canada or a foreign country; and
6. Original source transcripts are required if you were prepared in a foreign country or completed a generic to master accelerated program and,
7. 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.

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

**THE APPLICATION FEE IS NOT REFUNDABLE**

**SECTION 1. PROFILE INFORMATION**

<b>FULL LEGAL NAME</b>	FIRST	FULL MIDDLE OR "N/A"	MAIDEN	LAST
<b>ANY OTHER NAMES EVER USED</b>				
<b>DATE OF BIRTH</b>	/	/	<b>PLACE OF BIRTH</b>	CITY STATE
<b>SOCIAL SECURITY NUMBER</b>			<b>PERSONAL EMAIL ADDRESS</b>	
<b>MAILING ADDRESS *This is considered your public address</b>				

<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	<b>COUNTRY</b>
<b>RESIDENTIAL ADDRESS</b> (if different from above)			
<b>PHONE NUMBER(S)</b>	HOME	MOBILE	BUSINESS
<b>HIGH SCHOOL</b>	NAME	LOCATION	DATE OF GRADUATION / /
<b>G.E.D.</b>	<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 (including, but not limited to, the Maine State Board of Nursing) refused to issue you a  **YES**  **NO** 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?
- 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**
- 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 II 1. BASIC NURSING EDUCATION (First Registered Nurse Program )**

<b>SCHOOL OF PROFESSIONAL NURSING</b>	<b>NAME</b>
<b>ADDRESS</b>	
<b>DATE OF ENTRANCE</b> /     /	<b>DATE OF GRADUATION</b> /     /
<b>LENGTH OF PROGRAM</b>	
<b>IF PROGRAM IS LESS THAN 2 YEARS, PLEASE GIVE DETAILS (i.e. if you have a previous degree)</b>	

Diploma      Associate      Baccalaureate      Masters      Doctoral      Certificate

**SECTION IV. LICENSURE HISTORY**

ORIGINAL REGISTRATION:	YEAR	LICENSE NUMBER	BY EXAM
<b>STATE</b>			<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>COUNTRY</b> <i>if applicable</i>			<input type="checkbox"/> YES <input type="checkbox"/> 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**

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**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

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**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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## 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**

\_\_\_\_\_



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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:**  
(asit appears on the Card) \_\_\_\_\_

**Card Holder's Billing  
Address** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
**Card Holder's Signature** \_\_\_\_\_