



MAINE STATE BOARD OF NURSING

158 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA, MAINE 04333-0158
(207) 287-1152

APPLICATION FOR EXAMINATION AND LICENSE AS A REGISTERED PROFESSIONAL NURSE

DO NOT WRITE IN THIS SPACE

Application Received _____

Application Approved by Board of Nursing: _____

Fee: CC Cash Check

MO _____

Chair

Examination Date _____

Re-Examination Date(s) _____

Executive Director

LICENSE NUMBER _____

License Date _____

Date

INSTRUCTIONS

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

- Application form completed in **ink or typewritten**, with signature in applicant's handwriting;
- Fee of \$75.00 in the form of Visa/MasterCard/Discover Card, check or money order in U.S. funds, made payable to "Treasurer of the State of Maine";
- Recent passport type photograph (2 x 2 and no more than two years old) enclosed with the application form;
- Section VI. Declaration of Primary Residence must be completed with the state of primary residence and the date the state became your legal residence (not the date the application is complete);
- Register with Pearson Vue;
- 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. Register for fingerprinting on-line 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.

*An applicant **may** need the following:*

- Original source transcripts with degree conferred (for graduates of out of state programs only); and
- A detailed letter of explanation (circumstances/history of what happened), court documents (arrest and conviction, and DEEP and counselor documents (as applicable) is required for any "yes" answers in Section II.

For applicants requesting special accommodations to take the NCLEX-RN examination the following is required:

- You must register with Pearson Vue;
- You must provide the following documents as part of your application:
 - A signed request for the specific accommodations from you;
 - A letter from the school indicating the specific accommodations you received in your nursing program; and
 - A letter from your health care provider that details the testing and DSM code for your specific learning disability

Foreign applicants must contact the Commission of Graduates of Foreign Nursing Programs (CGFNS) and request a nursing transcript review (www.cgfns.com) and complete a Test of English TOEFL, IELTS, ELTS (to include reading, writing, listening, and speaking) if your nursing program was not taught in English.

THE APPLICATION FEE IS NOT REFUNDABLE

SECTION 1. PROFILE INFORMATION

FULL LEGAL NAME		FIRST	FULL MIDDLE OR "N/A"	MAIDEN	LAST
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 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 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. 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>(i.e. if you have a previous degree)</i>		

Diploma Associate Baccalaureate Masters Doctoral Certificate

Have you ever been licensed as a Practical Nurse? YES NO

If YES, indicate state(s), date(s) of licensure, and license number(s).

SECTION V. TO BE COMPLETED BY THE NURSE ADMINISTRATOR OF THE NURSING EDUCATION PROGRAM

I hereby certify that _____ (applicant's name) has successfully completed the prescribed

nursing education program on _____ (month/day/year) and will graduate on _____ (month/day/year)

SCHOOL SEAL

Signature

Printed Name

Title

Date

SECTION IV. EXAMINATION HISTORY

Have you ever taken an examination for Registered Nurse Licensure?

YES If YES, indicate state(s) and date(s). NO

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.



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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

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