

Advanced Practice Registered Nurse License Reactivation and Reinstatement Application

License Endorsement Application

License Type - Registered Nurse (RN)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

Title

First Name

Middle Name

Last Name

Maiden Name

Social Security Number

Date of Birth

Email Address

Phone Number

Other Phone Number

Citizenship

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?

What is your gender?

What is your ethnicity?

In which country were you born?

In which state were you born (if United States)?

In which city were you born?

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

Military Service

If you have served in the military, provide the information for the type of service and duration of service. You may be required to submit documentation of military status if required by the Board.

Have you served in the military?

If you answered "Yes", are you currently serving in the military?

Has your spouse served in the military?

If you answered "Yes", are they currently serving in the military?

I declined to answer these questions



Education History

To add an educational institution to your profile, click the ADD EDUCATION button. Begin typing the name of the school into the Education Institution field. As you type, the name of your school should auto-populate. Once it does, click on it to select it. If your school does not auto-populate, type and select Other. You will then enter your school's name and address in the fields that appear. Repeat this process for all education entries. All fields marked with (*) are required. Once finished, continue with the next Background sections or click the SAVE AND CONTINUE button. If you did not receive a degree, please select "Not Applicable" as the degree type and do not enter a graduation date.

Educational Institution -
Degree Type -
Degree - RN -
Graduation date -

Educational Institution -
Degree Type -
Degree -
Enrollment date
Graduation date -

Educational Institution -
Degree Type -
Degree -
Graduation date -

Employment History

*If you are applying for an RN: Are you currently employed in Ohio as an RN? If so, please identify employer and dates of employment. *If you are applying for a CRNA, CNS, CNM or CNP: If you are already engaged in the practice of nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, provide the period during which and the place where you are engaged, and the names and business addresses of your current collaborating physicians and podiatrists. A CRNA is not required to have a collaborating physician. To add an entry to your employment history, click the Add Work History button. Complete the information fields and click Save. Repeat this process for all employment entries. All fields marked with (*) are required.

Employer / Non-Working Activity -
Job Title -
Start Date -

End Date - 1
Average Hours/Week-
Supervisor -
Supervisor Phone Number-
Street Address -
Employment City -
Employment State -
Employment Zipcode -
Employment Country -

Employer / Non-Working Activity - -
Job Title -
Start Date -
End Date -
Average Hours/Week-
Supervisor -
Supervisor Phone Number-
Street Address -
Employment City -

Employment State -
Employment Zipcode -
Employment Country -

License Verification

If you are applying for an RN by Examination: This section is not required. To add a license you currently hold, click the Add License button. Complete the information fields and click Save. All fields marked with () are required. Repeat this process for each additional license you hold. To edit an added license, click the pencil icon.

Questions

Answer the following questions. Once completed, click "Save and Continue" to progress through the application.

Question - Are you currently engaged in the practice of nursing as a Certified Nurse Practitioner, in Ohio?

Answer -

Question - Have you ever practiced as a CNP in another state or U.S. territory?

Answer -

Question - Do you hold authority to practice in good standing in another jurisdiction as a CNP?

Answer -

Question - Enter that state and license number

Answer -

Question - Did you obtain national certification in your specialty from a national certifying organization on or before December 31, 2000?

Answer -

Question - Have you EVER been convicted of, found guilty of, pled guilty to, pled no contest to, pled not guilty by reason of insanity to, entered an Alford plea, received treatment or intervention in lieu of conviction, or been found eligible for pretrial diversion or a similar program for any of the following crimes. This includes crimes that have been expunged IF there is a direct and substantial relationship to nursing practice? A felony in Ohio, another state, commonwealth, territory, province, or country?

Answer -

Question - Have you EVER been convicted of, found guilty of, pled guilty to, pled no contest to, pled not guilty by reason of insanity to, entered an Alford plea, received treatment or intervention in lieu of

conviction, or been found eligible for pretrial diversion or a similar program for any of the following crimes. This includes crimes that have been expunged IF there is a direct and substantial relationship to nursing practice? A misdemeanor in Ohio, another state, commonwealth, territory, province, or country? This does not include traffic violations unless they are DUI/OVI or Physical Control While Under the Influence.

Answer -

Question - Have you been found to be a mentally ill person subject to hospitalization by court order, been found to be mentally incompetent by a probate court, or been found incompetent to stand trial by a court?

Answer -

Question - Has any board, bureau, department, agency or other body, including those in Ohio, **other than this board**, in any way limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you; placed you on probation; or imposed a fine, censure, or reprimand against you? Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate, or registration?

Answer -

Question - Have you ever, for any reason, been denied an application, issuance, or renewal for licensure, certification, registration, or the privilege of taking an examination, in any state (including Ohio), commonwealth, territory, province, or country?

Answer -

Question - Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, certificate, or registration in lieu of or in order to avoid formal disciplinary action with any board, bureau, department, agency, or other body, including those in Ohio, other than this Board?

Answer -

Question - Have you been notified of any current investigation of you, or have you ever been notified of any formal charges, allegations, or complaints filed against you by any board, bureau, department, agency, or other body, including those in Ohio, other than this Board, with respect to a professional license, certificate, or registration?

Answer -

Question - Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

Answer -

Question - Within the last five years, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

Answer -

Question - Have you, since attaining the age of eighteen or within the last five years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

Answer -

Question - Are you currently engaged in the illegal use of chemical substances or controlled substances? For this question “Currently” does not mean on the day of, or even weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a certificate holder or licensee, or within the past two years. “Illegal use of chemical substances or controlled substance” means the use of chemical substances or controlled substances obtained illegally (e.g. heroin, cocaine, or methamphetamine) as well as the use of controlled substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the direction of a licensed healthcare practitioner.

Answer -

Question - Are you required to register, under Ohio law, the law of another state, the U.S., or a foreign country, as a sex offender?

Answer -

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Title - National Certification

Description - I acknowledge that I will request that a Board approved national certifying organization send verification of my national certification directly to the Board via mail or email.

Attested -

Title - COA Transcript

Description - I will request that verification of my graduate degree with a major in a nursing specialty or in a related field that qualifies me to sit for a national certification exam and post master's certificate (if applicable) be sent to the Board by the program.

Attested -

Title -

Description -

Attached file -

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review -

Attestation

Your social security number is required by state and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the National Practitioner Data Bank (Public Law 100-93, Sec. 1921 of the Social Security Act, as amended; 45 C.F.R. pt. 60); reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

I am the person in this application and the statements made herein and the documents submitted are true and accurate.

I am requesting a designation to practice as a Certified Nurse Practitioner (CNP).

I will maintain certification by a national certifying organization approved by the Board in my designated area of advanced nursing practice. I understand that my license will be automatically suspended if I fail to maintain and provide documentation to the Board of current, valid certification by a national certifying organization.

I understand that as a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist I must practice only in accordance with a standard care arrangement entered into with one or more collaborating physicians or podiatrists. The standard care arrangement must comply with the criteria specified in Section 4723.431, ORC and Chapter 4723-8, OAC. I further understand that the standard care arrangement shall be retained and be available upon request. This requirement does not apply to employees of the Federal Veterans Administration (VA).

If I have not identified a collaborating physician/podiatrist, I will provide the Board the name and business address of each collaborating physician/podiatrist within 30 days after first engaging in practice. This requirement does not apply to employees of the Federal Veterans Administration (VA).

I have read and understand this Attestation and I am aware that misrepresentation on this application may result in disciplinary action in accordance with Section 4723.28, ORC.

I hereby request that in order to process my application, act upon renewal requests, and respond to public requests to confirm my license/certificate status, my personal information be accessed in accordance with 4723-1-11, OAC.

Consent to Electronic Signature -

Date/Time Stamp -

Type your First Name and Last Name as they appear on the application to sign electronically.

Submit your Application -After clicking the 'Submit' button below, you will no longer be able to change this

application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in. If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.