Attach a clear, full-face passport-style photograph (2″x 2″) of your head and shoulders, taken within the past six months.

A photo is required with each application.

Do not use staples to attach the photo.

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey Board of Nursing
124 Halsey Street, 6th Floor, P.O. Box 45010
Newark, New Jersey 07101
(973) 504-6430

Application for Advanced Practice Nurse Certification

(Do not submit this application unless and until you hold an active, valid New Jersey R.N. License.)

Date:_____

Please enclose a nonrefundable application filing fee of $100.00 in the form of a check or money order made out to the State of New Jersey. (Applicants should understand that if the fees are paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fees are paid.) You will also be required to pay a certification fee at a later date.

The Division is precluded by law from disclosing to the public the place of residence of licensees or applicants, without their consent. However, you are required to provide an address that may be released to the public in our directories or in response to other requests (by putting a check in the appropriate box). If you provide your place of residence as your public address of record, we will assume that you have consented to have that address be disclosed. If you do not consent to the disclosure of your place of residence, you should provide an address of record other than your place of residence that may be released to the public. One of your addresses must include a street, city, state and ZIP code.

Information that you provide on this application (including your address of record) may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

Date of birth: _____
Month Day Year

Place of birth: _____
City State

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
Last name First name Middle name Maiden name

2. Address

☐ Home: _____
Street or P.O. Box City State ZIP code County

_____ _____
Telephone number (include area code) E-mail address

☐ Business: _____
Name of company Telephone number (include area code)

_____
Street City State ZIP code County

☐ Mailing: _____
Street or P.O. Box City State ZIP code County

3. Social Security Number

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in denial/nonrenewal of licensure or certification.

*Social Security Number: _____ -_____ - _____

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7,60.8 and 60.9, the Board or Committee is required to obtain your Social Security number. Pursuant to these authorities, the Board or Committee is also obligated to provide your Social Security number to:

a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;

b. the Probation Division or any other agency responsible for child support enforcement, upon request; and

c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐ Yes ☐ No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual repayment of the loan. You will not be able to obtain a license or certificate unless you provide the required documents concerning the plan for repayment of your student loan.

6. Child Support

Please certify, under penalty of perjury, the following:

a. Do you currently have a child-support obligation? ☐ Yes ☐ No

(1) If "Yes," are you in arrears in payment of said obligation? ☐ Yes ☐ No

(2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months? ☐ Yes ☐ No

b. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No

c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No

d. Are you the subject of a child-support-related arrest warrant? ☐ Yes ☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

_____	_____	_____
Applicant's name (please print)	Applicant's signature	Date

7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a nurse" is to be construed to include all of the following:

a. The cognitive capacity to exercise the reasonable judgments of a nurse, and to learn and keep abreast of professional developments; and

b. The ability to communicate those judgments and related information to patients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform the duties of a nurse, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

"Chemical substance" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the 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 licensee, or within the previous two years.

"Illegal use of controlled dangerous substance" means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

a. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**?
☐ Yes ☐ No ☐ Not applicable

c. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? ☐ Yes ☐ No ☐ Not applicable

d. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No ☐ Not applicable

e. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
☐ Yes ☐ No

f. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") ☐ Yes ☐ No

If you answered "Yes" to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☐ No

** If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

_____ _____

Signature of applicant Date

8. Have you ever changed your name? ☐ Yes ☐ No
   If "Yes," please submit with this application a copy of the marriage certificate, divorce decree or court order.

9. Do you currently hold, or have you ever held, a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

   If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name. _____
   Last name First name Middle initial

Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired

10. Have you ever been disciplined or denied a professional license or certificate of any kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

11. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

12. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

13. Have you ever been named as a defendant in any litigation related to the practice of nursing or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

15. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

    If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

16. Are you aware of any investigation pending against a professional license or certificate issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

18. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to the practice of nursing or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If the answer to any of the above questions, numbers 10 through 18, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

19. Area of Clinical Specialty: _____
The New Jersey Board of Nursing only recognizes certain categories of Advanced Practice Nurses.

20. New Jersey Registered Nurse license number: _____

21. Are you certified or licensed for advanced nursing practice in another state(s)? ☐ Yes ☐ No
If "Yes," specify state(s) of certification or licensure. _____
You will need to obtain verification from these states. Refer to the enclosed Verification Request Form.

22. Entry-Level Nursing Education Completed: ☐ Diploma ☐ Associate Degree ☐ Baccalaureate Degree

_____ _____ _____
Name of nursing school | Date graduated | Credential

Entry-Level C.R.N.A. Education if not Master's Degree, as appropriate

_____ _____ _____
Name of program | Date graduated | Credential

23. Graduate Nursing Education Completed:
(Please have the official transcript(s) sent directly to the New Jersey Board of Nursing from the graduate nursing program(s).)

☐ Master's Degree in Nursing: _____ _____
Area of specialty | Date graduated

Name of Master's in Nursing Program:

_____

_____
Street address | City | State | ZIP code

☐ Post-Master's Nursing Certificate Program: _____ _____
Area of specialty | Date graduated

Name of Post-Master's Certificate Program:

_____

_____
Street address | City | State | ZIP code

24. Pharmacology Education Completed:

☐ Graduate Level Three-Credit Course _____
Date completed

☐ 30 Hours of Pharmacology* _____ _____
Date completed | No. of integrated pharmacy hours

*(*If pharmacology was integrated into various courses (rather than a separate pharmacology course), please complete the enclosed Completion of Integrated Pharmacology Form.)*

☐ Six (6) Contact Hours in pharmacology related to controlled dangerous substances, including pharmacologic therapy, and addiction prevention and management.
(Please complete the enclosed form.)

25. National Clinical Specialty Certification: ☐ Yes ☐ No Cite 7.1(b)
(Please have the Certifying Agency submit verification of your certification directly to the Board.)

Name of Certifying Agency: _____

Name(s) of certifying examination(s) that you passed/specialty: _____

_____

Certification date: From _____ to _____

If you are not certified, please complete the following:

Name of Certifying Examination _____

Name of Certifying Agency _____

Scheduled test date: _____

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____

County of: _____ } *ss.*

I, _____ , in making this application to the New Jersey Board of Nursing for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the New Jersey Board of Nursing, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Board.

I further swear (or affirm) that I have read N.J.S.A. 45:11-23 et seq., together with the Rules and Regulations of the New Jersey Board of Nursing, N.J.A.C. 13:37, and fully understand that in receiving licensure or certification from the Board, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board.

_____
Signature of applicant

Sworn and subscribed to before me this _____

day of _____ , _____
Month Year

_____
Name of Notary Public (please print)

_____
Signature of Notary Public

Affix Seal Here

Official Use Only
☐ Dual License
License Type 1
APN
Applicant's Number
License Type 2
Applicant's Number

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey Board of Nursing
P.O. Box 45010
Newark, New Jersey 07101
(973) 504-6430

Official Use Only
☐ Resubmit
Board or Committee

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name

2. Address _____
   Street or P.O. Box City State ZIP code

3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year

4. Social Security number _____/_____ / _____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history record background check process. No payment is necessary as of now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is $17.50.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

Certification

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey Board of Nursing
124 Halsey Street, 6th Floor, P.O. Box 45010
Newark, New Jersey 07101
(973) 504-6430

Advanced Practice Nurse Certification: Completion of Integrated Pharmacology

This will certify that _____, completed at least _____ hours of
Name of graduate

pharmacology integrated into the advanced nursing practice program completed at_____
Name of nursing program

on _____ .
Date

I hereby certify that the above statement is true and correct and affix my hand and school seal this _____ day of _____ , _____
Month Year

_____
Name of Dean/Director (please print)

_____
Signature of Dean/Director

_____
Name of Controlling Institute

_____
City State ZIP code

School Seal Here

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey Board of Nursing
124 Halsey Street, 6th Floor, P.O. Box 45010
Newark, New Jersey 07101
(973) 504-6430

Pharmacology Continuing Education Compliance Report Form

Name: _____ R.N. License Number: _____

A.P.N. Specialty/Category: _____

I certify that the foregoing statements made by me are true to the best of my knowledge. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment, including but not limited to suspension or revocation of a license and/or certification under N.J.S.A. 45:1-21.

Signature: _____

Title of Program **Attach copies of the certificates***	**Date**	**Program Provider**	**Contact Hours**
1 contact hour = 50 minutes **1 C.M.E./1 A.M.A. = 60 minutes = 1.2 contact hours** **A total of 30 contact hours is required.**			**Total** _____

***Attach a copy of the program certificate of completion/attendance (usually one page) for each listing noted above to add up to 30 contact hours.**

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey Board of Nursing
124 Halsey Street, 6th Floor, P.O. Box 45010
Newark, New Jersey 07101
(973) 504-6430

Advanced Practice Nurse Certification Verification Request: Certification of Advanced Nursing Practice

Directions: Complete only the top portion of this license verification form and forward it to the Board of Nursing in the state(s) in which you are or have been licensed. The board(s) should complete the form and return it to the New Jersey Board of Nursing. Note: Be advised that the board(s) completing the form may charge a fee for license verification. Please call the board(s) to check on fees for license verification prior to submitting this form.

Applicant name: _____
First name Middle name Last name Maiden name, if applicable

Current address: _____
Street City State ZIP code

This section is to be completed by the State Board of Nursing.

I hereby certify that _____ was issued certification/licensure
Name

as a _____
Clinical Specialty

(Check one): ☐ Nurse Practitioner ☐ Clinical Nurse Specialist

in the State of _____ on _____ .
Date

This certification/licensure expires on _____ .
Date

Has any disciplinary action been taken against any license or certification issued to this nurse to practice nursing?
(Check one): ☐ Yes ☐ No
If "Yes," please explain:

_____

_____

_____

I certify that the statements contained herein are true to the best of my belief, and I recommend this nurse for advanced nursing practice certification in the State of New Jersey.

_____
Executive Officer

_____
New Jersey Board of Nursing

_____
Date

Official Seal

Return to: New Jersey Board of Nursing, P.O. Box 45010, Newark, N.J. 07101