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

Re-Exam Application for Nurse Licensure by Examination - U.S. Graduates

Please check the license for which you are applying:

☐ **Registered Professional Nurse** ☐ **Licensed Practical Nurse**

Date: _____

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

2. Address _____
   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. Have you registered for PearsonVue? ☐ Yes ☐ No (If "No", you will not be able to proceed until registration is complete)

5. Has anything changed since your last application regarding:

Citizenship/ Immigration status?	☐ Yes	☐ No
Student Loan?	☐ Yes	☐ No
Child Support?	☐ Yes	☐ No
Medical Condition?	☐ Yes	☐ No
Name?	☐ Yes	☐ No
Criminal History?	☐ Yes	☐ No

Reasonable Testing Accommodations for Individuals with Disabilities. (Check if applicable)

☐ I have been diagnosed as having a disability and require special testing accommodations. Please send me the Request for Reasonable Testing Accommodations Form. I understand that I will not be able to test until I submit the appropriate documentation and am approved to test with accommodations.

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. 13:37-1 et seq., 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