



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

www.njconsumeraffairs.gov/nur/Pages/default.aspx

INSTRUCTIONS FOR ADVANCED PRACTICE NURSE CERTIFICATION IN N.J.

Please note that, pursuant to N.J.A.C. 13:37-7.2 an applicant must have completed his or her education no more than two years prior to submitting an application for certification. An education program completed more than two years prior to submission shall not qualify an applicant for certification.

Please read the following information carefully before completing an application for APN Certification.

If you previously held APN Certification in New Jersey, DO NOT complete this application. Please contact Rosann Lyons at (973) 273-8040 from the Board of Nursing.

1. Hold a current, active, and valid New Jersey license as a Registered Professional Nurse.
2. Request an application for APN Certification by submitting a request to: apn@dca.lps.state.nj.us.
3. Complete the application. Answer ALL of the questions.
4. Sign the application in the presence of a notary public.
5. Attach a clear, full-face original passport photograph (2" x 2") of your head and shoulders taken within the past six months. Sign your name on the back of the picture. (Photocopies and selfies are not acceptable.)
6. If you are a U.S.-born citizen, please submit a copy of your birth certificate or U.S. passport.
7. If you are a naturalized U.S. citizen, please submit a copy of your U.S. passport or certificate of naturalization.
8. If you are a legal alien or other immigration status, please submit your USCIS immigration documents. (Submit a copy of both the front and the back of your card.)
9. Submit proof of a legal name change (i.e., marriage license, divorce decree, court order) if your name differs from that on your birth certificate.
10. Complete the Certification and Authorization form for a criminal history background check and submit a check in the amount of \$17.50 made payable to the **State of New Jersey** for a fingerprint archive request.
11. Submit criminal history documents (if applicable).

12. Arrange to have a transcript from your master's or doctoral program submitted **directly** to the Board.
13. Arrange to have proof of valid APN Certification within your specialty from your national credentialing agency submitted **directly** to the Board.
14. Provide written verification of licensure in good standing from the state in which you were originally licensed, or are currently licensed, and from every state in which you have ever been licensed. The verification must be forwarded **directly** to the New Jersey Board of Nursing from the applicable state board(s), if those state(s) are not listed on the NURSUS License Verification Form.
15. Submit proof of completion of six (6) contact hours of a pharmacology course related to C.D.S.
16. Submit Certificates of Completion of 30 continuing education credits in pharmacology, if you graduated from your master's/doctoral program more than five (5) years ago.
17. Submit the nonrefundable application fee in the amount of \$100.00, made payable to the **New Jersey Board of Nursing**, in the form of a check or money order.
18. You will receive a letter from the Board advising you of the initial certification fee due, either \$80.00 or \$160.00, based on the expiration date of your RN license.

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.



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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.

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

Applicant's Number

License Type 2

Applicant's Number



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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



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**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 _____

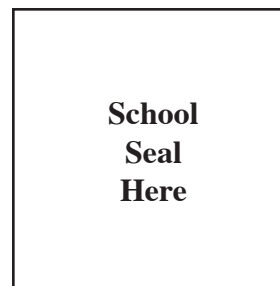
day of _____ , _____
Month Year

Name of Dean/Director (please print)

Signature of Dean/Director

Name of Controlling Institute

City State ZIP code





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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.



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**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