

Office of Professional Regulation  
 Vermont Board of Nursing  
**Advanced Practice Registered Nurse Endorsement Application**

2x2 Recent Photo-Paste Here	Application Fee: \$75.00
Passport sized photo of head and shoulder taken within the last 6 months.	Office Use Only

**Directions:**

Enclose each check or money order in the amount indicated, payable to "Office of the Secretary of State". **This application fee is non-refundable.**

You must complete each section of this form. **Please print clearly.**

**Section A:**

Name: _____				
(Last)	(First)	(Middle)	(Former/Maiden)	
Mailing address: _____				
(Street & P.O. Box)				
_____				
(City)	(State)	(Zip Code)		

Note: It is unprofessional conduct for a licensee to fail to notify the Secretary of State's Office of a change of name or address within thirty (30) days (3 V.S.A. § 129a(a)(14)).

If your 911 address is different from your mailing address, please indicate the 911 address here:


Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( mm/dd/yyyy ): _____
Social Security # _____ - _____ - _____	Place of Birth ( city, state, country ): _____

\*\*\*Providing your social security number (SSN) is mandatory, and requested under the authority granted by 42 U.S.C. § 405(c)(2)(C). It will be used by the Department of Taxes, Child Support, Labor and the Judiciary in the administration of Vermont law, to identify individuals affected by such laws. Your SSN is not disclosed as part of a public records request.

Home Telephone: (____) _____	Cell Phone: (____) _____
Work Phone: (____) _____	E-Mail Address: _____

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**Section B:**

Please answer yes or no to each of these questions. If the answer is yes please follow the provided instructions.

Have you ever committed any acts or omissions which are grounds for disciplinary actions such as those resulting in denial, conditions, revocation or limitations in hospital privileges? <i>If "Yes", provide a detailed written explanation and attach all related documents.</i>	Yes	No
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Have you ever committed acts of abuse, neglect, or misappropriation of patient property? <i>If "Yes", provide a detailed written explanation and attach all related documents.</i>	Yes	No
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Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) ever denied your application for a license, certificate, or registration in any profession or occupation? <i>If "Yes", attach an official copy of the order or official notification of the action.</i>	Yes	No
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Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) ever restricted, suspended, revoked, or taken any other disciplinary action against a license, certificate, or registration that you hold or held in any profession or occupation? <i>If "Yes", provide an official copy of the order or official notification of the action.</i>	Yes	No
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Have you ever surrendered a license, certificate, or registration to a licensing authority? <i>If "Yes", provide a detailed written explanation.</i>	Yes	No
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Are you currently under investigation by another licensing authority? <i>If "Yes", provide a detailed written explanation and a copy of any available information from the licensing authority.</i>	Yes	No
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Have you ever been convicted of a crime other than a minor traffic violation? (Driving While Intoxicated and Driving Under the Influence are not ___ minor) <i>If "Yes", provide a detailed written explanation and attach the official certified court documents.</i>	Yes	No
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Do you have any criminal charges pending against you in any jurisdiction (US or elsewhere)? <i>If "Yes", provide a detailed written explanation and attach a copy of the charges.</i>	Yes	No
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Do you have a physical or mental condition or disorder which in any way impairs or limits your ability to practice this profession with reasonable skill and safety? <i>If "Yes", please have your provider submit a detailed statement explaining how you are able to practice safely.</i>	Yes	No
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Do you use alcohol, drugs, or medications in any way that impairs or limits your ability to practice this profession with reasonable skill and safety? <i>If "Yes", provide a detailed written explanation.</i>	Yes	No
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Are you currently addicted to or in any way dependent on the use of alcohol or habit-forming drugs? <i>If "Yes", provide a detailed written explanation.</i>	Yes	No
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Are you currently participating in a supervised program or professional assistance program which monitors you in order to assure that you are not engaging in the use of alcohol or controlled substances? <i>If "Yes", please provide the contract/stipulation under which you are practicing.</i>	Yes	No
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Note: It is unprofessional conduct for a licensee to fail to report to the Office of Professional Regulation a conviction of any felony or any offense related to the practice of the profession in a Vermont district court, a Vermont superior court, a federal court, or a court outside Vermont within 30 days (3V.S.A. §129a(a) (11)).

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**Section C:**

**CHILDSUPPORT:**

ChildSupportOrders(15V.S.A.§795)  
 Asofthedateofthisapplication:(youmustcheck  one)

Iamnotsubjecttoachildsupportorder;OR  
 Iamsubjecttoachildsupportorderandamin  goodstanding\*orinfullcompliancewithaplanto  pay  
 Iamnotingoodstandingorinfullcompliance  withaplantopay.\*\*

**TAXES:**

TaxCompliance(32V.S.A.§3113(b)):  
 Asofthedateofthisapplication:(youmustcheck  one)

IhaveneverlivedorworkedinVermontanddon  otoweVermonttaxes;OR  
 notaxesaredueandpayableandallrequiredr  eturnshavebeenfiled;OR  
 theliabilityforanytaxesdueandpayableis  onappeal;OR  
 Iamincompliancewithapaymentplanapproved  bytheVermontDepartmentofTaxes;OR  
 Iamnotingoodstanding\*orinfullcompliance  withaplantopay.\*\*

**DISTRICTCOURTFINES/JUDICIALBUREAU:**

UnpaidJudgments(4V.S.A.§1110(c))  
 Asofthedateofthisapplication:(youmustcheck  one)

Idonothaveanyunpaidjudgments.  
 Iamingoodstanding\*withrespecttoanyunp  aidjudgmentissuedbythejudicialbureauordistr  ictcourtfor  
 finesorpenaltiesforaviolationorcriminaloffe  nse.  
 Iamnotingoodstanding.\*

\*"Goodstanding" is defined by various laws cited above. For more information, refer to the statute or consult the "information for applicants" on the Office of Professional Regulation webpage (www.vtprofessionals.org).  
 \*\*You may request that the licensing authority find that requiring immediate payment of child support due and payable would impose an unreasonable hardship. This form is available on the Office of Professional Regulation webpage.

**Section D:**

VTRN License Number \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
 (mm/dd/yyyy)

**Section E:**

<b>If you have completed a MASTER's program, provide the name and location.</b>	Name	
City	State	
<b>Area of Study:</b> _____	<b>Date Awarded:</b> _____	_____
	mm/dd/yyyy	y

<b>Provide the name and location of your APRN Program</b>	Name	City, State
<b>Area of Concentration</b>		
<b>Circle One</b> : Degree Certificate	<b>Date Awarded:</b> _____	
	mm/dd/yyyy	

<b>Provide the name and location of your APRN Program</b>	<b>Name</b>	<b>City, State</b>
<b>Area of Concentration</b>		
<b>Circle One</b> : Degree Certificate	<b>Date Awarded:</b> _____ mm/dd/yyyy	

Attach additional pages if necessary

Did your program include: Advanced Assessment Yes ___ No ___ Advanced Pharmacotherapeutics Yes ___ No ___ Advanced Pathophysiology Yes ___ No ___  How many supervised clinical hours were included in your program? _____  What was the clinical specialty focus of your program? _____
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**Section F: PRACTICER REQUIREMENTS**

1. I graduated from my entry level APRN education program within the last two years. Yes \_\_\_ No \_\_\_

If "Yes" date of graduation \_\_\_\_\_ Name of Nursing Program \_\_\_\_\_  
(MM/DD/YYYY)

If "No" complete the questions below.

2. I have practiced as an advanced practice registered nurse as defined in (Administrative Rules Section 15.8) for at least 50 days (400 hours) within the last 2 years or 120 days (960 hours) within the last five years:  
Yes \_\_\_ No \_\_\_

3. Provide the following information for all APRN employment within the last 5 years (paid, volunteer, or private duty work); attach additional sheets if necessary:

**Position #1 (most recent)**

Name of Employer: _____		Telephone Number (____) _____	
Employer's Mailing Address: _____ (Street/PO Box)			
(City)	(State)	(Country)	(Zip/Postal Code)
Supervisor's Name _____		Title: _____	
Supervisor's Telephone Number (____) _____		Email address: _____	
Job Title: _____		Paid or Volunteer _____	
Full Time or Part Time: _____			
Dates of Employment: From _____		To _____	
(MM/DD/YYYY)		(MM/DD/YYYY)	

**Position#2**

Name of Employer: _____		Telephone Number(____)_____	
Employers Mailing Address: _____			
(Street/PO Box)			
_____	_____	_____	_____
(City)	(State)	(Country)	(Zip/Postal Code)
Supervisor's Name _____		Title: _____	
Supervisor's Telephone Number(____)_____		Email address: _____	
Job Title: _____		Paid or Volunteer _____	
Full Time or Part Time: _____			
Dates of Employment: From _____		To _____	
(MM/DD/YYYY)		(MM/DD/YYYY)	

4. If you practiced as an advanced practice registered nurse in a private duty capacity or as a volunteer, attach:

**Private Duty:**

1. An Official letter from the Attending Provider on their letterhead, stating that APRN care was required. The letter must clearly list the Provider's name, title, contact telephone number and have their signature.
2. A letter from your Employer or Client, verifying your role and duties as a Private Duty Nurse Practitioner. They must verify the number of days, hours and dates worked. The letter must clearly list the Employer/Client's name, contact telephone number, email address, mailing address and have their signature.

**Volunteer:**

1. An Official letter from your Employer sent directly to the Vermont Board of Nursing office from the Director of Nursing or Director of Human Resources. A copy of your Job Description as a Volunteer APRN, and a letter listing the number of days, hours and dates worked. The letter must clearly list the name of the Director of Nursing or Director of Human Resources, their telephone number, email address, mailing address and have their signature.

5. If you have completed an APRN Refresher Course please attach a photocopy of your certificate of completion as well as the re-entry program curriculum, including total theory and clinical hours.

Name of APRN Re-entry/Refresher program: \_\_\_\_\_

Date APRN Re-entry/Refresher program completed: \_\_\_\_\_  
(MM/DD/YYYY)

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**Section G :Required Enclosures**

- Official copy of your transcripts released to you in a sealed envelope by the school from which you graduated. **Copies and unofficial transcripts will not be accepted.**
- This transcript must indicate successful completion of the following courses: Advanced Pathophysiology, Advanced Assessment and Pharmacotherapeutics
- Submit a copy of your current national advanced nursing practice specialty certification
- Practice guidelines must be the original, signed and dated by you and collaborating provider-if you are in the transition to practice period.
- If you do not require a Collaborative provider, practice guidelines must still be the original, signed and dated by you.
- Submit the APRN Attestation of Completion of Transition to Practice form if you have fulfilled the required hours.

**Copies and non-current practice guidelines will not be accepted.**

**Practice guidelines are required prior to employment.**

See *APRN Practice Guidelines Template* on Board of Nursing website for guidance in crafting your practice guidelines: [http://vtprofessionals.org/opr1/nurses/advanced\\_practice\\_registered\\_nurses.asp](http://vtprofessionals.org/opr1/nurses/advanced_practice_registered_nurses.asp)

Note-Practice guidelines must be approved by the Board prior to employment or change in clinical role, population focus or specialty.

**Section H:**

Once your license as an APRN has been approved, an new license will be sent to you. Your RN license will be placed on inactive status.

**Statement of Applicant**

I certify, under the pains and penalties of perjury, that all information I have provided in this application is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application for licensure/certification/registration. (The maximum penalty for perjury is fifteen years in prison and/or a \$10,000 fine. 13VSA §2901.)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date:

Please send completed application and fee to:  
 Attn: Board of Nursing  
 Office of Professional Regulation  
 National Life Building, North, Floor 2  
 Montpelier, VT 05620-3402  
[www.vtprofessionals.org/opr1/nurses](http://www.vtprofessionals.org/opr1/nurses)

Office of Professional Regulation  
 Vermont Board of Nursing

**Advanced Practice Registered Nurse  
Attestation Form  
Completion of Transition to Practice Requirement**

**\*Fill out and submit one form for each certification you hold. On each form, indicate whether you have practiced the required number of hours to fulfill the transition to practice requirement (2400 hours for primary credential; 1600 hours and 1 year for secondary credential)**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

License #: \_\_\_\_\_

Certification: \_\_\_\_\_  
(eg: FNP, ANP, PNP, CNM, CRNA, PMHNP (family, adult, child/adolescent); Psychiatric CNS (family, adult, child/adolescent))

Date certification first issued: \_\_\_/\_\_\_/\_\_\_  
(month/year)

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Total number of collaborative practice hours completed: \_\_\_\_\_

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Dates of practice that led to completion of transition to practice hours:  
\_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

**\*I certify under the pains and penalties of perjury, that all information I have provided in this document is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in action against me. (The maximum penalty for perjury is fifteen years in prison and/or \$10,000 fine. 3V.S.A. §2901)**

Signed: \_\_\_\_\_  
Signature Date

\_\_\_\_\_  
PRINT name of signature

Send completed form to:

Vermont Board of Nursing  
Office of Professional Regulation  
National Life Building, North, Floor 2  
Montpelier, VT 05620-3402