



FOR OFFICE USE ONLY

Receipt #

ID #

Issue Date

License #

**Rhode Island
Board of Nurse Registration and Nursing Education**

Room 105
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

License As A

- Registered Nurse**
 Licensed Practical Nurse

By Endorsement

Applicant - Print Name (First/MI/Last)

GENERAL INFORMATION

****VERY IMPORTANT****

Rhode Island is part of the Nurse Licensure Compact.

You do not need to apply for a RI license if you have an active license in the state where your legal residence is and this state is part of the Nurse Licensure Compact. Please visit <https://www.ncsbn.org/158.htm> in order to determine if your state is part of the Compact. Your employer needs to verify your nursing license by visiting <https://www.nursys.com>.

If your primary residence is in a state that is not part of the Compact, then you must obtain a RI license in order to practice in this state by completing this application.

For more information regarding the Nurse Licensure Compact, please visit our website at:

<http://www.health.ri.gov/for/nurses/>

Enclosures

The following materials and information should be enclosed within this application packet:

Application Process Overview.....	3
Instructions for Completing Application.....	4
Application Materials	
Application.....	5-8
Application Checklist.....	9
Interstate Verification Form - Original State of Licensure.....	10
Interstate Verification Form - Other State(s) of Licensure.....	11
Race/Ethnicity Questionnaire (Voluntary).....	12
Nursys License Verification Request Form - Original State of Licensure.....	13

Licensure Requirements - U.S. Graduates

- Fee of **\$130.00** for Registered Nurse, **\$90.00** for Licensed Practical Nurse.
- Recent passport type photograph.
- Official transcript from the school of nursing.
- Graduation from a nursing program.
- Photo copy of an **active, out-of-state license**.
- License Verifications from the board of original licensure, and all other state boards in which a license has been issued.
- Copy of evidence of primary address (eg. copy of driver's license, tax return, etc....)
- All applicants must apply to the Department of Attorney General ("AG") for a national background check supported by fingerprints and a state background check. The report **MUST** be sent directly from the Department of Attorney General ("AG") to the RI Board of Nursing.

APPLICATION PROCESS OVERVIEW

Foreign-Trained Nurses

- Requirements listed under U.S. Graduates.
- Completion of the requirements of the **Commission of Graduates of Foreign Nursing Schools**.
- Copy of evidence of primary address (eg. copy of driver's license, tax return, etc....)

Note: Information regarding the CGFNS can be obtained at its web site.

www.cgfns.org/cgfns/index.html

90-day Temporary License

- Once this application is processed by the Department, you will **automatically** receive a 90 day work permit, in the mail, along with a checklist stating what was received and what is needed to complete your application for permanent licensure.

Rules and Regulations/Laws

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

<http://www.health.ri.gov/atoz/>

The Nurse Practice Act can be downloaded at the following web site:

www.rilin.state.ri.us/statutes/title5/5-34/index.htm

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation, and the Rhode Island Board of Nurse Registration and Nursing Education (Board).

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 9) must be submitted for an application to be considered complete. All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year a new application must be submitted.

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice criminal or disciplinary history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received, and a decision to be made regarding issuance of your license.

<https://healthri.mylicense.com/Verification/>

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing. Be advised, you may be required to appear for an interview. NOTE: You may **not** practice in Rhode Island until you have received a license number.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-5700.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application pages (5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of **\$130.00** (for RN), or **\$90.00** (for LPN) payable to **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is **NONREFUNDABLE**.
3. Attach a copy of evidence of primary address (eg. copy of driver's license, tax return, etc...)
4. Complete all application materials as instructed and arrange them in the order listed on the application checklist (page 9). Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

**Rhode Island Department of Health
Board of Nurse Registration and Nursing Education
Room 105, 3 Capitol Hill
Providence, RI 02908-5097**

In addition to the materials you mail to HEALTH, the following must be either mailed or requested from other sources.

1. Official transcript from the school of nursing must be submitted by the college/school/university, directly to the Board, at the address listed above. **Fascimiles will not be accepted.** This transcript includes the date of completion, graduation, and degree. To be eligible for licensure in the State of Rhode Island, **you must be a graduate of a nursing program.**
2. Interstate Verification Forms. The original state of licensure must be verified at www.nursys.com Interstate Verification - Original State of Licensure form on Page 10, and all other licensing authorities in which you are/were licensed must be sent the form on Page 11 (which may be copied as needed). Be sure to sign and complete the identifying information on each form. HEALTH must receive these verifications directly from the licensing authority.
3. All applicants must apply to the Department of Attorney General ("AG") for a national background check supported by fingerprints and a state background check. The report **MUST** be sent directly from the Department of Attorney General ("AG") to the RI Board of Nursing.

You may obtain the mailing address of all U.S. licensing authorities at the National Council of State Boards of Nursing web site, or by calling the State Board in question.

www.ncsbn.org

Please, **do not** contact the Rhode Island Board for mailing addresses of other licensing authorities.



State of Rhode Island Board of Nursing Registration and Nursing Education

Application for License as a Registered Nurse by Endorsement

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

 - -

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."

3. Gender

 Male Female

4. Date of Birth

 / /

Month

Day

Year

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 -

Home Phone

State

Zip Code

Postal Code, If NOT U.S.

 -

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 -

Business Phone

State

Zip Code

Postal Code, If NOT U.S.

 -

Business Fax

Extension

7. Preferred Mailing Address

Please check ONE

- Please use my **Home Address** as my preferred mailing address
- Please use my **Business Address** as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended which led to your licensure as a nurse.

Type of School (University, College, Trade/Technical School etc.)

Name of School

Date Graduated:

State Month Day Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

Major

U.S Graduate Foreign Graduate

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? Yes No

If the answer to this question is "yes", list the original state of licensure, license number, original issue date, and, if applicable, enter all other state abbreviation(s) of licenses in Question 10 (below):

Original Licensure State and License Number **Original Issue Date**

State License Number Month Day Year

10. Nursing Licensure

List all states or countries in which you are now, or ever have been licensed to practice as a nurse, or any other profession.

State/Country: _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	State/Country: _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive



DOCUMENTATION: Send Interstate Verification Forms to each entity. (See pages 10 and 11)

Please indicate which state verifications you have requested through NURSYS (if any)

13. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Nurse Registration and Nursing Education any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as nurse in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Nurse Registration and Nursing Education of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp)

Signature of Notary

Notary Seal

Notary No/Commission No.

Commission Expiration Date (MM/DD/YY)

14. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.



Write your name on the back of the photograph, and provide the date that the photograph was taken.

Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- I have read and understand the "Instructions for Completing the Application".
- I have completed the Rhode Island Board application as instructed (pages 5-8).
- I have attached the cover page of the application.
- I have completed Section 13, "**Affidavit of Applicant**", and had the form notarized by a notary public.
- I have attached a photograph to Section 14, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- I have attached a photocopy of an active, out-of-state license.
- I have a **check or money order** (preferred), made payable (in U.S. funds only) to the "**RI General Treasurer**" in the amount of **\$130.00** (for RN) or **\$90.00** (for LPN) and attached it to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- I have arranged my Board Application materials in the following order.
 1. Fee (attached as instructed).
 2. Board Application (including cover page) (pages 5-8)
 3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application] MUST indicate the section for which the information is being reported.]
- I have mailed the above application materials directly to the Rhode Island Board of Nurse Registration and Nursing Education.
- I have enclosed evidence of my primary residence such as a copy of my driver's license, tax return, etc...

Required Forms

- I have completed and mailed the following forms or applied for verification at www.nursys.com as instructed.
 1. Interstate Verification Form - Original State of Licensure (Page 10) or Nursys Verification online at www.nursys.com
 2. Interstate Verification Form - to all other states of licensure

Other Documents

- I have requested a school transcript as instructed.
- I have requested a national background check supported by fingerprints and a state background check to be sent directly to the Board of Nursing.



Rhode Island Board of Nurse Registration and Nursing Education

Room 105, 3 Capitol Hill
 Providence, RI 02908-5097
 (401) 222-5700

INTERSTATE VERIFICATION FORM - ORIGINAL STATE OF LICENSURE

I am applying for a license to practice as a nurse in the State of Rhode Island. The Rhode Island Board of Nurse Registration and Nursing Education requires that the following form be completed by the jurisdiction in which I obtained my original license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Nurse Registration and Nursing Education at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
License Number	Date Issued	Daytime Phone Number

THIS SECTION TO BE COMPLETED BY THE NURSING BOARD

Nursing Education Program Completed:		Location:	Graduation Date:
Approved by State: <input type="checkbox"/> Yes <input type="checkbox"/> No		Type of Nursing Program <input type="checkbox"/> DIP <input type="checkbox"/> LPN <input type="checkbox"/> AD <input type="checkbox"/> BSN <input type="checkbox"/> Other _____	
Basis for Issuing License: <input type="checkbox"/> RN <input type="checkbox"/> LPN/VN		Licensed by Examination: <input type="checkbox"/> Yes <input type="checkbox"/> No	Exam Type:
Series:	Date:	Results:	CGFNS: <input type="checkbox"/> Yes <input type="checkbox"/> No
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed		Original Date Issued:	Expiration Date:

Questions:

1. Has this nurse ever been investigated by your Board? Yes No
2. Has this nurse incurred any disciplinary proceedings in your state, or is any action pending? Yes No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
4. Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

Signature _____ Date _____

Type or Print Name _____

Please Affix Board Seal Here

Title _____

Full Name of Licensing Board _____

Please return directly to the Board at the above address. Thank you for your prompt cooperation.



Rhode Island Board of Nurse Registration and Nursing Education

Room 105, Three Capitol Hill
 Providence, RI 02908-5097
 (401) 222-5700

INTERSTATE VERIFICATION FORM - OTHER STATES OF LICENSURE

I am applying for a license to practice as a nurse in the State of Rhode Island. The Rhode Island Board of Nurse Registration and Nursing Education requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Nurse Registration and Nursing Education at the above address.

_____	_____	_____
Print/Type Full Name	Signature	Date
_____	_____	_____
Previous Names Used	Social Security Number	Date of Birth
_____	_____	_____
License Number	Date Issued	Daytime Phone Number

THIS SECTION TO BE COMPLETED BY THE NURSING BOARD

Basis for Issuing License: <input type="checkbox"/> RN <input type="checkbox"/> LPN/VN		
Licensed by: <input type="checkbox"/> Endorsement <input type="checkbox"/> Waiver		
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

Questions:

1. Has this nurse ever been investigated by your Board? Yes No

2. Has this nurse incurred any disciplinary proceedings in your state, or is any action pending? Yes No

3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No

4. Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

_____	_____
Signature	Date

Type or Print Name	Please Affix Board Seal Here

Title	

Full Name of Licensing Board	

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Applicant: Print your complete last name >



State of Rhode Island and Providence Plantations Department of Health

This information is completely voluntary and will NOT affect your Application in any way.

VOLUNTARY RACE/ETHNICITY QUESTIONS*

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

1. Ethnicity: Are you Hispanic or Latino? (Mark “No” if not Hispanic or Latino.)

No, not Hispanic or Latino Yes, Hispanic or Latino

2. Race: What is your race? (Mark one or more.)

American Indian or Alaska Native Black or African American White
 Asian Native Hawaiian or other Pacific Islander

For the purposes of the above questions kindly use the “Federal Minimum Data Collection” explanations listed below:

1. Ethnic Categories:

Hispanic or Latino

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish origin” can be used in addition to “Hispanic or Latino.”

Not Hispanic or Latino

A person who is not Hispanic or Latino.

2. Racial Categories:

American Indian or Alaskan Native

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American

A person having origins in any of the Black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American”.

Native Hawaiian or Other Pacific Islander

A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

*This information is being collected in accordance with the Department of Health’s Policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.
