



\*\*\*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  
By Endorsement**

*Applicant - Print Name (First/MI/Last)*

Phone: (401) 222-5700

TTY/TDD: (800) 745-5555

Fax: (401) 222-3352

# GENERAL INFORMATION

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## **Enclosures**

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

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## **Licensure Requirements**

### **U.S. Graduates**

- Fee of \$130.00.
- 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.

Note: To check for current list of states that verify licensure through NURSYS, use the NURSYS web site of the National Council of State Boards of Nursing.

[www.nursys.com](http://www.nursys.com)

### **Foreign-Trained Nurses**

- Requirements listed under U.S. Graduates.
- Completion of the requirements of the **Commission of Graduates of Foreign Nursing Schools**.

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

[www.cgfns.org/cgfns/index.html](http://www.cgfns.org/cgfns/index.html)

### **90-day Temporary License**

- Non-renewable under any circumstances, and are issued only **once**

### **Rules and Regulations/Laws**

The rules and regulations governing the Practice of Nursing can be obtained at the following web site:

<http://www.health.ri.gov/hsr/professions/nurses.php>

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

[www.rilin.state.ri.us/statutes/title5/5-34/index.htm](http://www.rilin.state.ri.us/statutes/title5/5-34/index.htm)

# APPLICATION PROCESS OVERVIEW

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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.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. The BOARD may be emailed an address change. The email address is located at the following web site.

<http://www.health.ri.gov/hsr/professions/nurses.php>

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

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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** 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. 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 sent the 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.

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](http://www.ncsbn.org)

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







### 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 my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

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

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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** and attached it to the upper left-hand corner of the first (Top) page of the application.
- 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.

## Required Forms

- I have completed and mailed the following forms as instructed.
  1. Interstate Verification Form - Original State of Licensure
  2. Interstate Verification Form - to all other states of licensure

## Other Documents

- I have requested a school transcript as instructed.



# Rhode Island Board of Nurse Registration and Nursing Education

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

Substitute forms are not acceptable.

## INTERSTATE VERIFICATION FORM - ORIGINAL STATE OF LICENSURE

I am applying for a license to practice as a registered 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 _____	

### 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:	
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed		Original Date Issued:		CGFNS: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Expiration Date:					

**Questions:**

- Has this registered nurse ever been investigated by your Board?  Yes  No
- Has this registered nurse incurred any disciplinary proceedings in your state, or is any action pending?  Yes  No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes  No
- 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 _____	Please Affix Board Seal Here
Type or Print Name _____		
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

Substitute forms are not acceptable - This form may be duplicated as needed .

## INTERSTATE VERIFICATION FORM - OTHER STATES OF LICENSURE

I am applying for a license to practice as a registered 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	

### THIS SECTION TO BE COMPLETED BY THE NURSING BOARD

**Basis for Issuing License:**

RN     LPN/VN

**Licensed by:**

Endorsement     Waiver

**License Status:**

Active     Inactive     Lapsed

**Original Date Issued:**

**Expiration Date:**

**Questions:**

- Has this registered nurse ever been investigated by your Board?  Yes     No
- Has this registered nurse incurred any disciplinary proceedings in your state, or is any action pending?  Yes     No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes     No
- 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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Full Name of Licensing Board

Please Affix  
Board Seal Here

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.

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### VOLUNTARY RACE/ETHNICITY QUESTIONS\*

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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**

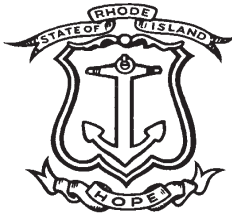
A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

##### **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.

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## Rhode Island Department of Health

3 Capitol Hill, Providence RI , 02908-5097

### MANDATORY ADDENDUM TO LICENSE APPLICATION Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. . These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

#### Licensee Declaration

- I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.
- I am currently pursuing administrative review of taxes owed to the state.
- I am in federal bankruptcy. (Case # \_\_\_\_\_)
- I am in state receivership. (Case # \_\_\_\_\_)
- I have been discharged from bankruptcy. (Case # \_\_\_\_\_)

\_\_\_\_\_  
Type of Professional License for which you are applying.

\_\_\_\_\_  
Full Name (Please Print or Type)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone Number (including area code if not 401)

\_\_\_\_\_  
Date

*This form must be completed, signed and attached to your license application for processing.*