

# Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810

Telephone: (225) 755-7500 • Fax: (225) 755-7581 or (225) 612-7005

website: [www.lsbn.state.la.us](http://www.lsbn.state.la.us)

## APPLICATION FOR SPECIAL HEALTHCARE EVENT TEMPORARY PERMIT

Please fax completed form to (225) 755-7581, or (225) 612-7005 if primary number is down, with copy of a valid Driver's License and proof of **current** nursing licensure in another state. Verification of temporary licensure in Louisiana is available at: [www.lsbn.state.la.us](http://www.lsbn.state.la.us).

### I. CURRENT INFORMATION

Applicant Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Alternate #: \_\_\_\_\_

State of Licensure: \_\_\_\_\_ License #: \_\_\_\_\_ Profession: \_\_\_\_\_ RN \_\_\_\_\_ APRN \_\_\_\_\_

Louisiana Address (if available): \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Site and Duration of Practice in Louisiana for the Special Healthcare Event:

Hospital or Agency / Site: \_\_\_\_\_

Hospital Contact Name and Phone #: \_\_\_\_\_

Anticipated Duration: \_\_\_\_\_

### II. COMPLIANCE QUESTIONS

YES _____ NO _____	1. Been arrested, charged with, convicted of, pled guilty or no contest to, or been sentenced for any criminal offense, including all misdemeanors and/or felonies in any state/county/jurisdiction?
YES _____ NO _____	2. Had any voluntary surrender, disciplinary action, consent order or settlement agreement imposed or is any disciplinary action, consent order, or settlement agreement imposed or is any disciplinary action pending on your license in any state (including Louisiana)/country or jurisdiction? Have you had other than an honorable discharge from the military?
YES _____ NO _____	3. Been named in a civil/malpractice case relating to your employment as a nurse? Have you been reported to the National Practitioner Data Bank? Have you had clinical privileges suspended, revoked or limited?
YES _____ NO _____	4. Have or had a physical, mental or emotional condition that might affect your ability to practice safely as a registered nurse or advanced practice nurse?

### ATTESTATION

I, \_\_\_\_\_ affirm that I am the person referred to in this application for a Special Healthcare Event Temporary Permit as a Registered Nurse/Advanced Practice Registered Nurse in the State of Louisiana; that all statements herein contained are true in every respect; that I have complied with all requirements of the law; and that I have read and understand all sections of this application. I understand falsification of any information contained in this application may result in denial of a Special Healthcare Event Temporary Permit and/or board disciplinary action.

**NOTE: Attach copy of picture identification and proof of active nursing licensure in another state.**

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## VERIFICATION OF EMPLOYMENT FOR SPECIAL HEALTHCARE EVENT TEMPORARY PERMIT

### **Instructions:**

**This form must be completed by the company/institution representative**, who is requesting an RN or APRN to practice in the State of Louisiana during a special healthcare event when that nurse does not hold an active Louisiana nursing license.

The RN (or APRN) who wishes to provide **gratuitous** nursing care during a special healthcare event, must hold an active and unencumbered RN/APRN license in another U.S. State and have answered 'No' to all of the Compliance Questions on the Application for Special Healthcare Event Temporary Permit form.

Please **return this completed/signed form back to the nurse** so he/she can send to LSBN *along with* the required Application for Special Healthcare Event Temporary Permit form, photo ID *and* proof of valid/current nursing licensure in another U.S. State for processing.

### ***PLEASE TYPE OR PRINT LEGIBLY***

This is to certify that \_\_\_\_\_ has been hired to provide **gratuitous** nursing services in Louisiana for the below named Special Healthcare Event:

Name of Event: \_\_\_\_\_

Date(s) of Event: \_\_\_\_\_

Company / Agency Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address of Contact: \_\_\_\_\_

\_\_\_\_\_  
**Print** name of company/institution representative & title

\_\_\_\_\_  
*Signature* of the above company representative verifying employment

\_\_\_\_\_  
Date signed

***Verification of a Special Healthcare Event Temporary Permit having been issued can be obtained free of charge at the LSBN website under LICENSURE VERIFICATION.***