

Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810

Main Telephone: (225) 755-7500

www.lsbn.state.la.us

Dear Applicant:

This packet contains the **2012 Application for Reinstatement by Advanced Practice Registered Nurse and required forms**. Completed applications and forms must be **mailed** to the Board of Nursing for processing; **faxed copies are not acceptable**. Please note the continuing education (CE) and nursing practice requirements for re-licensure must be met in order to reinstate your license. If you have not worked in nursing for 5 years or more, please contact our *Reinstatement Department* for further information **before** submitting an application for reinstatement. All fees are non-refundable.

If your Louisiana Advanced Practice Registered Nurse license has been Inactive, Delinquent or Retired for *five (5) years or more*, you are **required** to submit to a Criminal Background Check (CBC) as part of the reinstatement process. Please refer to the Fingerprint Instructions and Authorization Forms for Criminal Background Check available at the LSBN website which explains the CBC process, additional CBC fee and authorization forms that would be submitted along with your application for reinstatement. A copy of the additional CBC documents will print out at the end of this packet.

An APRN license cannot be reinstated until the Louisiana RN licensure status is active.

Please submit all required documents and fees together in one complete packet to avoid delays in the processing of your reinstatement request. Incomplete or partial application packets can not be processed.

Please indicate the documents being submitted to meet the requirements for reinstatement/relicense:

- Application for Reinstatement by Registered Nurse.
- Application for Reinstatement by Advanced Practice Registered Nurse.
- \$200.00 Reinstatement fee (\$100.00 for each application – RN & APRN). **Money Order or Bank Cashier's Checks only.** Personal Checks and/or Cash are **not** accepted. Fees are subject to change
- Copy of current certification/recertification letter or card issued by the national nursing certification organization approved by the Louisiana State Board of Nursing in your APRN role and population focus/specialty.
NOTE - APRN's applying for reinstatement of an advanced practice role and population focus/specialty where certification is not available, shall submit the following documentation for **each year** of inactive or lapsed status:
 - * minimum of 300 hours of practice as a fully licensed or permitted APRN for each year of inactive or lapsed status up to a maximum of 800 hours;
 - and**
 - * a minimum of two college credit hours relevant to the advanced practice role and population focus/specialty for each year; **or**
 - * a minimum of 30 continuing education contact hours approved by the Board relevant to the advanced practice role and population focus/specialty for each year. Continuing medical education (CME) units/credits may be utilized by the APRN to meet this requirement.
- Criminal Background Check packet with additional money order if inactive for 5 years (or more), **or if otherwise required as directed in the separate RN Reinstatement Application, Section III, question # 1.**

Rules regarding Requirements for Reinstatement/Relicensure may be located the LSBN website: www.lsbn.state.la.us, Chapter 33, in subsection 3335.D-F. Applications expire one year from date submitted.

NOTE: Louisiana nursing licenses are **calendar** year licenses that must be renewed each fall for the next year. All licenses expire January 31st if not successfully renewed online by the nurse prior to this deadline.

LOUISIANA STATE BOARD OF NURSING

17373 Perkins Road, Baton Rouge, LA 70810

Phone: (225) 755-7500

www.lsbns.state.la.us

APPLICATION FOR REINSTATEMENT BY REGISTERED NURSE

LICENSE NO.	2012 YEAR
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FOR OFFICE USE ONLY	
MONEY ORDER NO. _____	CASHIERS CHECK NO _____
CE _____	VOE _____ APPROVED _____

PRINT ALL INFORMATION BELOW (Legal documentation must be provided for name change)

APPLICANT'S CURRENT MAILING ADDRESS & CONTACT INFORMATION:

Applicant's Current Name: _____
Current Mailing Address: _____
City, State & Zip: _____
Home Phone Number: (_____) _____
Cell Phone Number: (_____) _____
E-mail Address: _____

EMPLOYER ADDRESS:

Employer Name: _____
Address: _____
City, State & Zip: _____
Employer Phone Number: (_____) _____

COMPLETE THIS APPLICATION IN BLUE OR BLACK INK.

READ SEPARATE INSTRUCTIONS PAGE FIRST. ANY ERROR WILL DELAY YOUR LICENSE REINSTATEMENT.

Section I. I Hereby Apply For:

_____ Active Status from Inactive/Retired/Delinquent Status **\$100.00 fee**

APPROPRIATE FEES MUST BE SUBMITTED ALONG WITH THIS APPLICATION -

- Please read the full Instructions for Applying for RN Licensure by Reinstatement before submitting this application to ensure you are eligible to apply.
- **Money Order or Bank Cashier's Checks only.** Personal Checks or Cash are **not** accepted.
- Fees are NOT refundable

Applications not completed within one (1) year from date of submission will be closed and cancelled

Section II. Requirements for Reinstatement/Relicensure

I have met the requirements for reinstatement/relicensure by: (select **one** of the following options below and submit documentation demonstrating compliance along with this application and reinstatement fee)

Note: Nursing Continuing Education (CE) certificates of completion to document contact hours must show the nursing course completed by the individual was approved/accredited by *either* the American Nurses Credentialing Center (ANCC) **or** a U.S. State Board of Nursing.

_____ Five (5) LSBN approved contact hours of nursing continuing education (CE) and employment verification of at least 1600 hours of nursing practice last year (full-time).

_____ Ten (10) LSBN approved contact hours of nursing continuing education (CE) and employment verification of at least 160 hours of nursing practice last year, but under 1600 hours (part-time).

_____ Fifteen (15) LSBN approved nursing continuing education contact hours for each year since my Louisiana RN license became inactive/delinquent. I had less than 160 hours of nursing employment last year.

_____ Documentation showing completion of a RN Refresher Course approved by the Louisiana State Board of Nursing (list available on LSBN website) as evidence of compliance with requirements for individuals unlicensed or with non-nursing practice for four (4) years or more (Rule 3335.D.2.a)

_____ Initial Licensure for the State of Louisiana was issued during 2011.

_____ Certification in a nursing specialty recognized by the LSBN Board (see LSBN website for full list)

_____ Written request for CE exception due to active military service for a minimum of six (6) months in the last year (Rule 3335.2.b) Applicant must provide copy of military photo ID and written proof of service dates.

Section III. Compliance

YOU ARE HEREBY DIRECTED TO DISCLOSE ALL APPLICABLE MATTERS AS FOLLOWS:

1. Yes__No__ Have you ever been issued any of the following:

- a citation or summons for, *and/or*
- has/have warrant(s) been issued against you related to, *and/or*
- have you been arrested, charged with, arraigned, indicted, convicted of, *and/or*
- pled guilty/"no contest"/nolo contendere/"best interest" or any similar plea to, *and/or*
- been sentenced for any criminal offense, including all misdemeanors and felonies, in any state or other jurisdiction?

NOTE: Even though an arrest or conviction has been pardoned, expunged, dismissed, deferred, **or** diverted, and even if your civil rights have been restored, you must answer "**YES**" and mail certified court documents of incident/arrest together with a signed letter of explanation.

- **DWI arrest must be reported, regardless of final disposition.**
- **Traffic violations such as speeding or parking tickets do not need to be reported.**

If the above question was answered 'Yes', then:

Yes__No__ Have you previously reported/provided the following information to the Louisiana State Board of Nursing?

If you answered '**No**' here, and/or had not reported/provided the following, then submit with application:

- *Provide a narrative explanation (dated and signed) with date of any/all citations, summons, warrants, arrests, charges, arraignments indictments, convictions, pleas, sentence,*
- *the name of parish/county in which arrests, etc., occurred,*
- *the names of arresting agencies,*
- *the violation(s) listed,*
- *the final disposition of any/all criminal matters, and current status, if no final disposition.*
- *Enclose certified true copies of any/all arrest report(s), etc., occurrence/narrative/supplemental reports; certified true copies of any/all court minute entries and court judgments/orders; copies of probation/DA diversion or Pretrial Intervention programs, etc., and any/all other relevant records.*
- **Immediately submit to a Criminal Background Check (CBC) as part of the reinstatement application process.** Click on the link to "[Fingerprint Instructions and Authorization Sheet for Criminal Background Check](#)" available at the LSBN website. *Please read instructions carefully.* Fingerprinting may be completed at LSBN Board Office located at 17373 Perkins Road, Baton Rouge, Louisiana 70810, Monday through Friday 9:00 AM to 3:00 PM (excluding holidays), **or** may be completed at your local law enforcement office as explained in the fingerprinting instructions. Two FBI fingerprint cards, both CBC authorization sheets and additional CBC fee must be submitted along with this application for processing.

Name of Applicant (provide at top of each page): _____

2. **Yes__No__** Have you had a license to practice nursing or as another health care provider denied, revoked, suspended, sanctioned, or otherwise restricted or limited, including voluntary surrender of license - including restrictions associated with participation in confidential alternatives to disciplinary programs? *and/or*
- Have you had disciplinary action pending by a licensing board—other than by Louisiana State Board of Nursing—in any state or jurisdiction?**

If either of the above questions were answered 'Yes', then:

Yes__No__ Have you previously reported/provided the following information to the Louisiana State Board of Nursing? If you answered '**No**' here, and/or had not reported/provided the following, then submit with application:

- *Provide a narrative explanation (dated and signed) with date of and description of any/all actions by other licensing boards in Louisiana and in other states or jurisdictions (**beside the Louisiana State Board of Nursing**), including names of other boards at issue, status of any/all disciplinary matters with other boards,*
- *Enclose certified true copies of any/all other board actions by other licensing boards, along with any/all related and/or subsequent actions.*

3. **Yes__No__** Have you been discharged from the military on ground(s) other than an honorable discharge?

If the above question was answered 'Yes', then:

Yes__No__ Have you previously reported/provided the following information to the Louisiana State Board of Nursing? If you answered '**No**' here, and/or had not reported/provided the following, then submit with application:

- *Provide a narrative explanation (dated and signed) of the other-than-honorable discharge, with date(s) of incident(s) involved, detailed description of grounds for discharge, along with description of the surrounding circumstance and any/all other relevant information.*
- *Enclose photocopies of any/all military discharge documents, including any/all documentation of the underlying action(s) that resulted in discharge, with any/all other related records.*

4. **Yes__No__** Have you been named as a defendant in a civil/malpractice case relating to your practice of nursing? *and/or*

Has a medical review panel opinion been rendered relating to your practice of nursing? *and/or*

Have you been reported to the National Practitioner Data Bank? *and/or*

Have your clinical privileges been suspended, revoked, restricted or limited?

If any of the questions above were answered 'Yes', then -

Yes__No__ Have you previously reported/provided the following information to the Louisiana State Board of Nursing? If you answered '**No**' here, and/or had not reported/provided the following, then submit with application:

- *Provide a narrative explanation (dated and signed) with date(s) of incident(s) involved, detailed description of the incident(s) at issue along with description of the surrounding circumstances, information regarding the current status of the Medical Review Panel opinion, civil or medical malpractice suit(s), and any/all other relevant information.*
- *Enclose photocopies of any/all Medical Review Panel opinions, civil or medical malpractice suit(s), along with any/all related records*

Name of Applicant (provide at top of each page): _____

5. **Yes__No__** Have you been diagnosed with, do you have, or have you had a medical, physical, mental, emotional or psychiatric condition that might affect your ability to safely practice as a Registered Nurse?

If the above question was answered 'Yes', then:

Yes__No__ Have you previously reported/provided the following information to Board staff or the Recovery Nurse Program? If you answered '**No**' here, and/or had not reported/provided the following, then submit with application:

- *Provide a narrative explanation (dated and signed) with date(s) of incident(s) involved, detailed description of the condition(s) at issue, diagnoses, treatment received so far, treatment planned or prescribed, information regarding the current status of your condition(s), date, name and location of any/all treating facility(ies) and/or treating caregiver(s), number of times in treatment, currently-prescribed medication(s), and any/all other relevant information. Include in your statement if you are going to apply, or have applied, for Social Security or insurance disability.*
- *Enclose photocopies of any/all discharge summaries, relevant medical records and/or treatment record.*
- *Written, signed & dated, statement(s) from treating physician(s) addressing current ability to safely practice nursing, and any/all related records must be sent directly to LSBN by the treating physician. (Letter and envelope should indicate ATTN: Reinstatement Department)*

6. **Yes__No__** Have you had a problem with, been diagnosed as dependent upon, or been treated for mood-altering substances, drugs or alcohol? *and/or*

Have you been diagnosed as dependent upon, addicted to, or been treated for, dependence upon medications?

If either of the above questions were answered 'Yes', then -

Yes__No__ Have you previously reported/provided the following information to Board staff or the Recovery Nurse Program? If you answered '**No**' here, and/or had not reported/provided the following, then submit with application:

- *Provide a narrative explanation (dated and signed) with date(s) of incident(s) involved, detailed description of the condition(s) at issue, diagnoses, treatment received so far, treatment planned or prescribed, information regarding the current status of your condition(s), date, name and location of any/all treating facility(ies) and/or treating caregiver(s), number of times in treatment, currently-prescribed medication(s), and any/all other relevant information. Include in your statement if you are going to apply, or have applied, for Social Security or insurance disability.*
- *Enclose photocopies of any/all discharge summaries, relevant medical records and/or treatment record.*
- *Written, signed & dated statement(s) from treating physician(s) addressing current ability to safely practice nursing, and any/all related records must be sent directly to LSBN by the treating physician. (Letter and envelope should indicate ATTN: Reinstatement Department)*

Name of Applicant (provide at top of each page): _____

Section IV. Practice Attestation

Please check **one** of the following:

_____ I attest that I have **not** practiced as a registered nurse in Louisiana during the period that my RN licensure status has been inactive/retired/delinquent.

OR

_____ I attest that **I have practiced** as a registered nurse in Louisiana during the period that my RN licensure status has been inactive/retired/delinquent.

NOTE - Complete the section below in full if you worked without an active license, providing name and address of the employer, the dates worked and fill in the 'Statement of Explanation' section regarding why you had worked without a current/active licensure in Louisiana.

Name/Address of Employer: _____

Dates of Employment: from _____ to _____
(Provide the actual date last worked: month/day/year)

Statement of Explanation: _____

Section V. Attestation / Signature / Identifying Information

I hereby apply for reinstatement of my Louisiana Registered Nurse license and attest by my signature below that to the best of my knowledge, information and belief, all statements that I have made are true and correct and that I have not withheld any information that might affect this application. I understand that failure to disclose and/or falsification of any information accompanying or contained on this application will result in denial of relicensure and may result in disciplinary action. I further certify that I am in compliance with the continuing education (CE) and nursing practice requirements for relicensure and agree to supply supporting documents. I hereby authorize the Louisiana State Board of Nursing to conduct a criminal records check and authorize the Louisiana State Police and the Federal Bureau of Investigation to release all criminal record information maintained in their file, which may confirm or deny my eligibility for reinstatement/relicensure.

Signature: _____ Social Security Number _____

Date: _____ Date of Birth _____

Note: Attach copies of continuing educational (CE) certificates, signed RN Employment Verification form (or letter of explanation if not recently employed), and fee to mail along with this completed/signed reinstatement application.

LOUISIANA STATE BOARD OF NURSING

17373 Perkins Road, Baton Rouge, LA 70810

Phone: (225) 755-7500

www.lsbnp.state.la.us

APPLICATION FOR REINSTATEMENT BY ADVANCED PRACTICE REGISTERED NURSE

		2012
LICENSE NO.		YEAR

FOR OFFICE USE ONLY	
MONEY ORDER NO. _____	CASHIERS CHECK NO. _____
CE _____	VOE _____ APPROVED _____

PRINT ALL INFORMATION BELOW (Legal documentation must be provided for name change)

APPLICANT'S CURRENT MAILING ADDRESS & CONTACT INFORMATION:

Applicant's Current Name: _____

Current Mailing Address: _____

City, State & Zip: _____

Home Phone Number: (____) _____

Cell Phone Number: (____) _____

E-mail Address: _____

EMPLOYER ADDRESS:

Employer Name: _____

Address: _____

City, State & Zip: _____

Employer Phone Number: (____) _____

COMPLETE THIS APPLICATION IN BLUE OR BLACK INK.

READ SEPARATE INSTRUCTIONS PAGE FIRST. ANY ERROR WILL DELAY YOUR LICENSE REINSTATEMENT.

Section I. I Hereby Apply For:

_____ **Active Status from Inactive/Retired/Delinquent Status** **\$100.00 fee**

APPROPRIATE FEES MUST BE SUBMITTED ALONG WITH THIS APPLICATION -

- Please read the full Instructions for Applying for APRN Licensure by Reinstatement before submitting this application to ensure you are eligible to apply.
- **Money Order** or **Bank Cashier's Checks only**. Personal Checks or Cash are **not** accepted.
- Fees are NOT refundable

Applications not completed within one (1) year from date of submission will be closed and cancelled.

Section II. Current/Primary Employment as an APRN:

Please indicate your anticipated employment as an APRN:

1. Category

- ____ CNS
- ____ CNM
- ____ CRNA
- ____ NP

2. Clinical Specialty

- ____ Anesthetist (CRNA)
- ____ Midwife (CNM)
- ____ Acute Care NP
- ____ Adult NP
- ____ Family NP
- ____ Gerontological NP
- ____ Neonatal NP
- ____ Oncology CNS
- ____ Pediatric NP
- ____ School NP
- ____ Women's Health Care NP
- ____ Adult Psychiatric & Mental Health CNS
- ____ Child/Adolescent Psychiatric & Mental Health CNS
- ____ Community Health CNS
- ____ Gerontological CNS
- ____ Home Health CNS
- ____ Adult Health CNS (formerly Medical – Surgical)
- ____ Maternal Child CNS
- ____ CNS in Acute and Critical Care - Adult
- ____ CNS in Acute and Critical Care - Pediatric
- ____ CNS in Acute and Critical Care - Neonatal
- ____ Adult Psychiatric and Mental Health NP
- ____ Family Psychiatric and Mental Health NP
- ____ Clinical Nurse Specialist in Pediatric Nursing
- ____ Other _____

3. Clinical Setting

- ____ Outpatient Clinic
- ____ College Student Health Clinic
- ____ Emergency Department
- ____ HIV/AIDS Clinic
- ____ Hospital
- ____ Nursing Home
- ____ Pediatric Clinic
- ____ Physicians Office
- ____ Private Clinic
- ____ Medicine Clinic
- ____ Rural Clinic
- ____ School Clinic
- ____ Urban Clinic
- ____ Women's Health Clinic
- ____ School of Nursing
- ____ Other _____

Section III. Advanced National Certification

Note: If originally licensed in Louisiana under the grandfathered provision (Commensurate Requirements) *and not nationally certified*, leave this section (Section III) blank. Complete and attach a "Verification of [Renewal] Reinstatement Requirements for APRNs without National Certification" form (VR-1) and proof of CE requirements, and proceed to Section IV.

If **nationally certified**, then proceed with this section and submit documentation of current certification. If certified in more than one specialty area. Indicate advanced national certification as it applies to primary and secondary employment.

For example, you are certified as a Family NP from ANCC and Women's Health Care NP from NCC, but you are employed as a FNP, primary certification would be ANCC and secondary certification would be NCC.

1. National Certifying Organization (Select only one in each column)

<u>Primary</u>	<u>Secondary</u>	
___	___	National Board on Certification & Recertification of Nurse Anesthetists (NBCRNA/AANA)
___	___	American Midwifery Certification Board (AMCB)
___	___	American Academy of Nurse Practitioners (AANP)
___	___	American Nurses Credentialing Center (ANCC)
___	___	Pediatric Nursing Certification Board (PNCB)
___	___	National Certification Corporation of Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)
___	___	Oncology Nursing Certification Corporation (ONCC)
___	___	American Association of Critical Care Nurses Certification Corporation (AACN)

2. Specialty Area (Select only one in each column)

<u>Primary</u>	<u>Secondary</u>	
___	___	Nurse Anesthetist
___	___	Certified Nurse Midwife
___	___	Acute Care Nurse Practitioner
___	___	Adult Nurse Practitioner
___	___	Family Nurse Practitioner
___	___	Gerontological Nurse Practitioner
___	___	Neonatal Nurse Practitioner
___	___	Oncology Clinical Nurse Specialist
___	___	Pediatric Nurse Practitioner
___	___	School Nurse Practitioner
___	___	Women's Health Care Nurse Practitioner
___	___	Adult Psychiatric and Mental Health Nursing Clinical Specialist
___	___	Child and Adolescent Psychiatric and Mental Health Nursing Clinical Specialist
___	___	Community Health Nursing Clinical Specialist
___	___	Gerontological Nursing Clinical Specialist
___	___	Home Health Clinical Specialist
___	___	Adult Health Clinical Specialist (formerly known as 'Medical – Surgical Nursing')
___	___	Maternal Child Clinical Specialist
___	___	Clinical Nurse Specialist in Acute and Critical Care - Adult
___	___	Clinical Nurse Specialist in Acute and Critical Care - Pediatric
___	___	Clinical Nurse Specialist in Acute and Critical Care - Neonatal
___	___	Adult Psychiatric and Mental Health Nurse Practitioner
___	___	Family Psychiatric and Mental Health Nurse Practitioner
___	___	Clinical Nurse Specialist in Pediatric Nursing

3. Certification Expiration date: _____ ***Attach copy of documentation of current certification.***

Section IV. Practice Verification

Check one of the following:

___ I attest that **I have not practiced** as an advanced practice registered nurse in Louisiana during the period that my APRN licensure status has been inactive/retired/delinquent; **OR**

___ I attest that **I have practiced** as an advanced practice registered nurse in Louisiana during the period that my APRN licensure status has been inactive/retired/delinquent. (*Submit statement of explanation with employer name/address and dates*)

Section V. Attestation / Signature / Identifying Information

I hereby apply for reinstatement of my Louisiana Advanced Practice Registered Nurse (APRN) license and attest by my signature below that to the best of my knowledge, information and belief, all statements that I have made are true and correct and that I have not withheld any information that might affect this application. I understand that failure to disclose and/or falsification of any information accompanying or contained on this application will result in denial of relicensure and may result in disciplinary action. I hereby authorize the Louisiana State Board of Nursing to conduct a criminal records check and authorize the Louisiana State Police and the Federal Bureau of Investigation to release all criminal record information maintained in their file, which may confirm or deny my eligibility for relicensure.

Signature: _____

Social Security Number _____

Date: _____

Date of Birth _____

Louisiana State Board of Nursing

ADDITIONAL INSTRUCTIONS AND FORMS FOR COMPLETING A CRIMINAL BACKGROUND CHECK FOR REINSTATEMENT FOLLOW THIS DIVIDER PAGE

A Criminal Background Check (CBC) is required for Reinstatement *when*:

- The reinstatement applicant has not held an active Louisiana nursing license for five (5) years or more, *and/or*
- If otherwise required as directed in Section III, question # 1 of the RN Reinstatement Application. See page 2 of the RN reinstatement application for further details regarding this compliance question.

Please read all questions on the Reinstatement application(s) carefully. Failure to disclose and/or falsification of any information on an application, form(s) or other records submitted to the Louisiana State Board of Nursing is cause for denial of licensure and can result in disciplinary action.

Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810

Telephone: (225) 755-7500

www.lsbns.state.la.us

FINGERPRINT INSTRUCTIONS FOR CRIMINAL BACKGROUND CHECK (CBC)

- 1) **Authorization Forms:** Complete, sign and date **both** of the following CBC authorization forms and submit to LSBN together with the appropriate licensure application (if applicable), fees, and two (2) fingerprint FBI cards:
 - * **CBC1a:** [Authorization for Criminal Background Check – Page I](#)
 - * **CBC1b:** [Authorization for Criminal Background Check – Page II](#)
- 2) **Fingerprinting:** Contact your state or local police/sheriff's office to inquire about their procedures, fees and locations for fingerprinting services. You will need to be fingerprinted onto two (2) official Federal Bureau of Investigation (FBI) fingerprint cards. If your local law enforcement office does not have FBI cards, Board staff can mail you a set of blank FBI cards upon written request. Fill out the [Request for Blank Fingerprint Cards](#) form, indicate which department you will be submitting the CBC (and application, where applicable) at the top, and fax to LSBN. If providing the CBC fingerprints cards & authorization sheets to apply for initial licensure or reinstatement in Louisiana, they must accompany your application.
 - Each of the two (2) FBI cards need a separate and distinct set of your fingerprints. If the agency utilizes an electronic scan system, request that they scan your fingerprints and print the first FBI card, then scan your fingerprints again and print the second FBI card.
 - The following suggestions may improve print quality and ensure LSBN staff receive your CBC results promptly:
 - Hands must be clean and dry. Wash your hands vigorously with warm water and dry thoroughly immediately prior to being fingerprinted.
 - If hands are very dry or cracked, wash hands and apply a touch of moisturizer onto fingertips, removing any excess lotion with paper towel prior to being fingerprinted. This may help raise the ridges for printing.
 - L.A.C.46:XLVII.3330 J-K states:
 - J. If the fingerprints are returned from the Department of Public Safety as inadequate or unreadable, the applicant, or licensee must submit a second set of fingerprints and fees, if applicable, for submission to the Department of Public Safety.*
 - K. If the applicant or licensee fails to submit necessary information, fees, and/ or fingerprints, the applicant or licensee may be denied licensure on the basis of an incomplete application or, if licensed, denied renewal, until such time as the applicant or licensee submits the applicable documents and fee.*
 - View both FBI cards before you leave the facility where you're being fingerprinted. If any of the fingerprints are outside the boxes, appear too light, too dark, or obviously smudged - have the technician prepare an extra set of cards and submit **both sets** (all four cards) along with your application. **Protect both FBI cards from smudges. Do not fold or staple.**
 - All fingerprint cards must be signed by the nurse with all sections filled out completely with the exception of the "employer and address" section.
 - Individuals who are *already licensed Registered Nurses* may have their fingerprints scanned at the LSBN office (LiveScan) between 8:30am and 3:00 pm. Please arrive early to allow time for fingerprint scanning & processing.
- 3) **Fees due LSBN for CBC:**
 - \$42.50 – Payable to Louisiana State Board of Nursing (LSBN) if paper FBI fingerprint cards are submitted
 - **OR** -
 - \$52.50 – Payable to Louisiana State Board of Nursing (LSBN) if coming in person to the LSBN office to have your hands scanned using the LiveScan equipment. (**Licensed Registered Nurses only**).

All fees must be paid by Money Order or Bank Cashier's Check, payable to LSBN

NOTE: If you are submitting to a CBC because you are applying for licensure or permission to enroll in clinical nursing courses, please read the **application instructions** carefully regarding payment of fees. Some application instructions will provide a 'total fee' to submit with the application which may include the CBC fee noted above.

(Criminal history records check is authorized under the Nurse Practice Act, **Louisiana Revised Statutes 37:920.1**)

Authorization for Criminal Background Check (CBC) – Page I

****FORMS MUST BE FILLED OUT IN INK AND BE REVIEWED BY SUBMITTING AGENCY/INDIVIDUAL FOR ACCURACY****
******FINGERPRINTS ARE NECESSARY FOR A POSITIVE IDENTIFICATION******

Fees for CBC (money order or bank cashier's check required, payable to LSBN):

- \$42.50 – Payable to Louisiana State Board of Nursing (LSBN) if paper FBI fingerprint cards are submitted
- OR -
- \$52.50 – Payable to Louisiana State Board of Nursing (LSBN) if coming in person to the LSBN office to have your hands scanned using the LiveScan equipment. (Licensed Registered Nurses only).

**** Refer to your Application Instructions to see if the above CBC cost if already incorporated in the application fee total****

******PLEASE PRINT (except 'Signature) – USE BLUE OR BLACK INK WHEN FILLING OUT THIS FORM ******

Louisiana State Board of Nursing

FACILITY OR AGENCY

Patricia A. Dufrene, MSN, RN

FACILITY OR AGENCY AUTHORIZED REPRESENTATIVE

Cynthia York, RN, MSN, CGRN

FACILITY OR AGENCY AUTHORIZED REPRESENTATIVE

17373 Perkins Road

MAILING ADDRESS

SIGNATURE OF LSBN AUTHORIZED REPRESENTATIVE

Baton Rouge, LA

CITY STATE

70810

ZIP CODE

(225) 755-7500

FACILITY OR AGENCY PHONE NUMBER

Request For: (pick one only)

- ALCOHOL AND BEVERAGE COMMISSION
- ALCOHOL BEVERAGE OUTLET
- CASA
- CONCEALED HANDGUNS
- CRIMINAL JUSTICE EMPLOYEE
- DAYCARE
- DENTISTRY BOARD
- DEPARTMENT OF LABOR
- DEPARTMENT OF PUBLIC SAFETY
- EMPLOYERS
- FIREFIGHTERS
- GAMING
- HEALTH CARE PROVIDER
- IMMIGRATION
- JUVENILE DETENTION CENTER
- DEPARTMENT OF INSURANCE
- MANUFACTURED HOUSING
- MEDICAL EXAMINERS
- OCS FOSTER/ADOPTIVE
- OCS PERSONNEL

- OFFICE OF FINANCIAL INSTITUTIONS
- OFFICE OF PUBLIC HEALTH
- PHARMACY BOARD
- POSTSECONDARY EDUCATION
- PRACTICAL NURSING
- PRIVATE ADOPTION
- PRIVATE INVESTIGATORS
- PRIVATE SECURITY
- PUBLIC HOUSING
- PUBLIC TAG AGENT
- REGISTERED NURSING
- RELIGIOUS ACTIVISTS
- RIVERBOAT PILOTS
- SCHOOL
- SENATE AND GOVERNMENTAL AFFAIRS
- TAXI DRIVERS
- USED MOTOR VEHICLE COMMISSION
- VOLUNTEERS WITH YOUTH SERVING ORGANIZATIONS

**** Please print all but Signature ****

APPLICANTS NAME: _____

LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME (if different)
{Provide any and all 'other' Last Names held which are not listed above in the bottom margin of this page}

APPLICANTS SIGNATURE: _____

APPLICANTS SOCIAL SECURITY # ___ - ___ - ___ DATE OF BIRTH: ___ / ___ / ___

DRIVERS LICENSE #: _____ & STATE _____ RACE _____ SEX _____

POSITION OR LICENSE APPLIED FOR _____

AUTHORIZATION TO DISCLOSE CRIMINAL HISTORY RECORDS INFORMATION

By my signature above, I hereby authorize the Louisiana State Police to release all pertinent criminal record information maintained in their files, other states files, or the FBI files (if applicable) which may confirm or deny my eligibility with the facility or agency named above.

Authorization for Criminal Background Check (CBC) – Page II

**APPLICANT PROCESSING-DISCLOSURE
BUREAU OF CRIMINAL IDENTIFICATION AND
INFORMATION
P.O. BOX 66613 (MAIL SLIP A-6)**

LSPAPPR/R8.03

LOUISIANA STATE BOARD OF NURSING
AGENCY

NOTICE:

PLEASE PRINT OR TYPE INFORMATION,
EXCLUDING ADMINISTRATORS OR
AUTHORIZED PERSON SIGNATURE.
INCOMPLETE FORMS WILL NOT BE
PROCESSED.

17373 Perkins Road

MAILING ADDRESS

Baton Rouge

CITY

LA

STATE

70810

ZIP CODE

Endorsement applicant to provide the following information below:

APPLICANT'S FULL NAME (print)

_____/_____/_____
DATE OF BIRTH

_____/_____
RACE SEX

SOCIAL SECURITY NUMBER

**ALL INFORMATION RELEASED MUST REMAIN STRICTLY CONFIDENTIAL AND ONLY
THOSE AUTHORIZED BY LAW TO RECEIVE THIS INFORMATION MAY SUBMIT A REQUEST.**

DO NOT WRITE BELOW THIS LINE: (FOR BUREAU OF CRIMINAL IDENTIFICATION AND INFORMATION USE ONLY)

NOTICE: The response to your request for a criminal history check is based on a review of the State of Louisiana's criminal history records database as is available at the time of request. This does not preclude the possible existence of conviction information not available in our database.

CRIMINAL HISTORY DETERMINATION:

RAPSHEET ATTACHED

RESPONSE BELOW

FORM NBR: CBC – 1b

Revised: 2/08, 6/11, 3/12

Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810

Telephone: (225) 755-7500

Credentialing Fax Number: (225) 755-7581

www.lsbns.state.la.us

REQUEST FOR BLANK FINGERPRINT CARDS

I am required to submit to a Criminal Background Check (CBC) as authorized by the Nurse Practice Act, Louisiana Revised Statutes 37:920.1. I am unable to obtain Federal Bureau of Investigation (FBI) cards from my local law enforcement agency; therefore I am requesting two (2) blank fingerprint cards to be mailed to me by the Louisiana State Board of Nursing (LSBN).

Please indicate the department you will later be submitting an application for Louisiana licensure for this request. Check one box below, complete bottom and fax to the number listed above.

- **RN Licensure by Endorsement** (already licensed as an RN outside of Louisiana)
- **RN or APRN Licensure by Reinstatement** (I held a Louisiana RN or APRN license previously)
- **APRN Licensure by Endorsement or Examination**

Full Name: _____

Mailing Address: _____

Home Phone Number: _____

Work Phone Number (please include extension): _____

Cell Phone Number: _____

E-mail Address: _____

***** Please do not submit your application until you have received and completed the FBI fingerprint cards. Your full CBC packet must accompany your application *****