

Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810

Tel: (225) 755-7500 Fax: (225) 755-7581

www.lsbns.state.la.us

INSTRUCTIONS FOR APPLYING FOR APRN LICENSURE BY ENDORSEMENT

We are pleased that you are requesting licensure as an Advanced Practice Registered Nurse (APRN) in Louisiana. In the State of Louisiana, licensure is mandatory for a Certified Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM) and Certified Registered Nurse Anesthetist (CRNA). You may not practice as an APRN or utilize any associated titles in Louisiana until the Louisiana State Board of Nursing (LSBN) has issued to you an APRN license.

Following are instructions to apply for Advanced Practice Registered Nurse licensure in the State of Louisiana **by endorsement**. You are expected to complete all applications and forms carefully, correctly, and accurately. Incorrect or incomplete applications will delay licensure. Falsifying applications is illegal. If you have *never* been licensed as an APRN *in another U.S. State*, please see the separate application for Initial APRN licensure by Examination in the LSBN Nurse Portal. If you were previously licensed as an APRN in Louisiana, but that license is inactive/lapsed, instructions and forms on how to apply for Reinstatement are also available in the LSBN Nurse Portal.

NOTE: Louisiana nursing licenses initially issued are **calendar** year licenses that must be renewed before the expiration date. Subsequent renewals are biennial (every 2 years). All licenses expire January 31st if not successfully renewed online by the nurse prior to the expiration date.

All fees are non-refundable. The application fee is \$100, and the fee for a criminal background check is \$39.25 (and is subject to change periodically).

If you wish to apply for licensure in more than one role or population (i.e. FNP and AGACNP or CNM and WHNP), you must submit an application for APRN licensure **and** a separate application for licensure in an *additional* role/population after the initial APRN license is issued. You may not apply for licensure in more than one role or population in a single application.

The applicant will be notified via the Nurse Portal when the application has been approved or if additional information is required. Check the Nurse Portal for status updates as well as the email entered as the username in the Nurse Portal for correspondence. Any additional information needed and approval letters will be sent only to the email address associated with the Nurse Portal account.

SECTION A: ELIGIBILITY CRITERIA FOR APRN LICENSURE BY ENDORSEMENT

1. Possess a current/valid, unrestricted Louisiana Registered Nurse (RN) license;
2. Possess a minimum of a graduate degree or post graduate award with a concentration in the respective APRN role and population focus from an accredited college or university that meets the curriculum guidelines established by the Louisiana State Board of Nursing;

*Consideration may be given to those who prior to December 31, 1995 had completed or been continuously enrolled in a formalized post-basic education program preparing for the APRN role and population focus.
3. Possess current national certification in the specific APRN role and population focus for which you are applying to LSBN for licensure;
4. Possess current clinical practice/competency or completion of the APRN educational program within 2 years;
5. Possess current licensure in another state as an APRN;
6. Not have grounds for or pending disciplinary action upon your Louisiana RN or other APRN licenses;
7. Not have pending disciplinary action by any nursing or other health regulatory board in any US state or in a country outside the US; and
8. Not have pending civil or criminal charges in any US state or in a country outside the US;

SECTION B: REQUIREMENTS FOR COMPLETING THE APPLICATION

1. Applicant must submit completed application for endorsement, fees and other required documents within one (1) year of LSBN having received the application;
2. Applicant must cause to have sent directly to the LSBN, an official set of **transcripts**. Electronic submissions are accepted from escip, Parchment, or the National Student Clearinghouse. Official transcripts are those provided directly from the university/school that issued course credit or the school's authorized transcript service as previously named. Transcripts will not be accepted from applicants, even if mailed to the LSBN in a sealed envelope;
3. Applicant must cause to have mailed directly to the LSBN **Verification of Advanced Practice Education** (form **AP2**) sent directly to the LSBN by the university/school that awarded the educational degree;
4. Applicant must cause to have mailed or emailed directly to the LSBN **Verification of Certification** sent directly to the LSBN by the certifying body;
5. Applicant must submit evidence of initial APRN licensure in another US state, territory, or country;
6. Applicant must submit evidence of current **APRN licensure** issued directly from the jurisdiction of last employment;
7. An original, signed, notarized **Affidavit of Verification** sent directly to the LSBN office **via US postal mail**; <http://www.lsbn.state.la.us/Portals/1/Documents/Forms/AffadavitofVerificationAPRN.pdf>; and
8. Applicant must submit to a **criminal background check** (CBC). The criminal history record information check is authorized under the Nurse Practice Act, Louisiana Revised Statutes 37:920.1 and are required as part of the licensure process. The **CBC packet along with a copy of your receipt of payment must be submitted *directly to the LSBN via postal mail after you have* submitted the APRN application.** A complete CBC packet consists of: two (2) CBC authorization forms, two (2) FBI fingerprint cards, and the CBC fee. Obtain the forms and instructions at <http://www.lsbn.state.la.us/Portals/1/Documents/orbs/ENDFingerprintAuthorizationsForm.pdf>.
9. Submit a copy of a current/valid government issued photo identification (i.e. US Residency Card or Green Card, passport or driver's license) which is required to be electronically uploaded during the application process.

SECTION C: APRN TEMPORARY PERMITS are available only in very select circumstances and are *not available to new graduates*.

To be eligible to request an APRN temporary permit, you must meet one (1) of the following criteria:

- have a two (2) or more year gap between education and/or clinical experience and the date your application for licensure as an APRN is submitted to LSBN; *or*
- have applied (or now applying) to LSBN for reinstatement of your prior Louisiana APRN license, and national recertification is pending; *or*
- have otherwise been directed by the Board regarding eligibility to apply for the temporary permit.

If you meet one of the requirements for an APRN temporary permit as explained above, please provide along with your application a signed written explanation that indicates which criteria applies.

If you have any questions regarding the APRN application process, please call (225) 755-7517 or (225) 755-7500 (option # 6) and ask to be connected to the Licensing Analyst handling APRN licensure.

******Prior to engaging in medical diagnosis and management as an APRN, including writing orders and/or prescriptions, the APRN must obtain a letter of approval issued to the nurse by LSBN indicating approval for prescriptive authority (PA) privileges in the State of Louisiana in collaboration with licensed physician(s). The separate application required to apply for initial PA privileges in Louisiana is available on the LSBN Nurse Portal. The nurse must wait until his/her Louisiana APRN license has been issued (i.e. 'active') before the nurse can submit application forms to obtain LSBN approval for PA privileges. Please Note – If you have ever had a previous arrest (even if charges/arrest were later expunged or dismissed) and/or past board action that was not already disclosed and reviewed by LSBN Board staff, then additional documentation will be required when applying for APRN licensure. Along with the APRN application, submit the information requested in the associated compliance question within the application.**

LOUISIANA STATE BOARD OF NURSING

17373 Perkins Road, Baton Rouge, LA 70810 * (225) 755-7500 * Fax: (225) 755-7581 * www.lsbn.state.la.us *

VERIFICATION OF ADVANCED PRACTICE NURSING EDUCATION

PART I – APRN Applicant Information

Applicant Instructions: Fill out the **top** portion of this form and forward to the educational institution from which you obtained your advanced practice nursing education. This form must be completed and submitted to the Louisiana State Board of Nursing (LSBN) office **directly** by the educational institution. An **official** set of transcripts indicating an advanced practice nursing degree was **conferred** (or certificate issued if post-grad) must also be **mailed directly** to LSBN by the School.

Name (First, Middle, Maiden, Married):		
Street Address:		
City:	State:	Zip Code:
Social Security #:		Date of Birth:
Louisiana RN License Number:		Expiration Date:
Signature of Applicant:		Date Signed:

PART II – Verification of Advanced Practice Education

Educational Institution Instructions: Please complete the following information, noting any exceptions to the information requested. Please fill out all portions of this form and mail to the Louisiana State Board of Nursing (LSBN) at the address noted above. An **official set of the applicant's conferred transcripts** must also be mailed to LSBN **directly** from the School.

Name of Educational Institution: _____		
I certify that _____ completed the advanced nursing program		
<small>print name of graduate above</small>		
indicated below and completed ALL requirements for conferring a Master's degree in nursing or Post Graduate award/ certificate as of the date this form has been signed and not after.		
Type of Advanced Nursing Educational Program:	Advanced Practice Role:	
<input type="checkbox"/> * Certificate <input type="checkbox"/> Post Graduate <input type="checkbox"/> * Diploma <input type="checkbox"/> Doctorate <input type="checkbox"/> Masters <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Certified Nurse Midwife (CNM) <input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA) <input type="checkbox"/> Clinical Nurse Specialist (CNS) <input type="checkbox"/> Certified Nurse Practitioner (CNP)	
<small>* Certificate or Diploma only applicable if enrolled <i>prior</i> to December 1995</small>		
Provide the <i>specific</i> APRN Role and Population Focus completed by graduate: _____ (Examples: CRNA; CNM; Family NP; Adult NP; Pediatric NP; Adult Psychiatric Mental Health CNS, etc.)		
Date Enrolled: _____	Date Completed (provide month, day, and year): _____	
		(SEAL)
_____ Signature of Program Administrator		_____ Date Signed

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Name (First, Middle, Maiden, Married):		
Street Address:		
City:	State:	Zip Code:
Social Security #:		Date of Birth:
Louisiana RN License Number:		Expiration Date:
Signature of Applicant:		Date Signed:

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Name of Educational Institution: _____															
I certify that _____ completed the advanced nursing program <small style="margin-left: 100px;">print name of graduate above</small>															
indicated below and completed ALL requirements for conferring a Master's degree in nursing or Post Graduate award/ certificate as of the date this form has been signed and not after.															
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Type of Advanced Nursing Educational Program:</th> <th style="text-align: left;">Advanced Practice Role:</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> * Certificate</td> <td><input type="checkbox"/> Certified Nurse Midwife (CNM)</td> </tr> <tr> <td><input type="checkbox"/> * Diploma</td> <td><input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA)</td> </tr> <tr> <td><input type="checkbox"/> Masters</td> <td><input type="checkbox"/> Clinical Nurse Specialist (CNS)</td> </tr> <tr> <td><input type="checkbox"/> Other (specify): _____</td> <td><input type="checkbox"/> Certified Nurse Practitioner (CNP)</td> </tr> <tr> <td><input type="checkbox"/> Post Graduate</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Doctorate</td> <td></td> </tr> </tbody> </table>	Type of Advanced Nursing Educational Program:	Advanced Practice Role:	<input type="checkbox"/> * Certificate	<input type="checkbox"/> Certified Nurse Midwife (CNM)	<input type="checkbox"/> * Diploma	<input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA)	<input type="checkbox"/> Masters	<input type="checkbox"/> Clinical Nurse Specialist (CNS)	<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Certified Nurse Practitioner (CNP)	<input type="checkbox"/> Post Graduate		<input type="checkbox"/> Doctorate		
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Date Enrolled: _____	Date Completed (provide month, day, and year): _____														
(SEAL)															
_____ Signature of Program Administrator	_____ Date Signed														

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FINGERPRINT INSTRUCTIONS FOR CRIMINAL BACKGROUND CHECK (CBC)

- 1) **Authorization Forms:** Complete, sign and date **both** CBC authorization forms included on the pages that follow these instructions.
 - * **CBC1a:** [Authorization for Criminal Background Check – Page I](#)
 - * **CBC1b:** [Authorization for Criminal Background Check – Page II](#)

Submit the authorization forms to LSBN at the address above together with the two (2) fingerprint Federal Bureau of Investigation (FBI) cards.

***Students submit completed cards to the office of your program head.**
- 2) **Fingerprinting:** Submit to the LSBN office **two (2)**, separate official FBI level fingerprint cards on the fingerprint form FD-258. Fingerprinting must be completed by trained individuals who are authorized to provide fingerprinting services at their agency (i.e. law enforcement facilities including state or local police/sheriff's offices, campus security, private vendors). Contact the agency to inquire about the procedures, fees and locations for fingerprinting services. If the agency does not have blank FBI cards, print paper cards at the following link to bring to the agency for fingerprinting services: <https://www.fbi.gov/file-repository/standard-fingerprint-form-fd-258-1.pdf/view>.
 - Each of the two (2) FBI cards need a separate and distinct set of your fingerprints. If the agency utilizes an electronic scan system ('LiveScan'), request they scan both hands for your fingerprints and print the first (1st) FBI card, then scan your hands again to print your fingerprints on the second (2nd) FBI card.
 - The following suggestions may improve the quality of your fingerprints to ensure LSBN receives the results of your CBC 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:
 - 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.
 - 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 fingerprinting agency where you're being fingerprinted. If any of the fingerprints appear too light or too dark, or are obviously smudged, or are outside of the boxes on the fingerprint card, request that the technician prepare an additional set of cards and submit **both sets** (all four cards) along with your forms. ***Protect all FBI cards from smudges. Do not fold or staple. Do not submit 2 copies of the same prints.***
 - All fingerprint cards must be signed by the applicant/nurse with all sections filled out completely with the exception of the "employer and address" section.
- 3) **Fee due to LSBN for CBC:**
 - \$39.25 – Paid electronically with submission of applications through the Louisiana Nurse Portal.
 - Contact the LSBN office about payment of the fee if you are submitting to a background check and have not submitted the fee in association with an application.

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 along 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******

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

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

See instructions for submission of fees.

Louisiana State Board of Nursing

FACILITY OR AGENCY

Patricia A. Dufrene, PhD, RN

FACILITY OR AGENCY AUTHORIZED REPRESENTATIVE

Monique Calmes, APRN, FNP-BC

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 except Signature ****

APPLICANT 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)

APPLICANT SIGNATURE: _____

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

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

LICENSE APPLIED FOR: Student RN by examination/NCLEX RN by endorsement
 Other APRN Conversion to compact license RN reinstatement

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, FBI and/or international files (if applicable) which may confirm or deny my eligibility with the facility or agency named above.

FORM NBR: CBC – 1a

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

Provide/print 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

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REQUEST CORRECTION TO APPLICATION

Complete and submit this form if you have submitted an application online that is currently being processed **and** you have made an error in completion of that application and are requesting to make a correction to the information provided. ***Do not submit this form if you submitted the wrong application or wish to revise your response to eligibility questions #1-20.*** You may be asked to provide additional supporting documentation to support your request. Applicants are expected to complete all applications and forms carefully, correctly, and accurately. Incorrect or incomplete applications will delay processing of an application. Falsifying applications is a violation of the Louisiana Nurse Practice Act and LSBN Rules.

*** Submit this form by composing and sending a message through the **Message Center** in your **Louisiana Nurse Portal** account. Select the application type as the topic of the message and upload this completed document as an attachment when sending the message.

Name: _____ Date of Birth: _____

Last 4 digits of social security#: _____

Application type submitted with an error (i.e. endorsement, student clinical, etc.): _____

Select One:

- I am requesting to revise an error in my request for controlled substance privileges.
- I am requesting to revise an error in my demographic information (i.e. spelling of name, date of birth, etc.).
- I am requesting to revise an error in my _____.

All applicants must provide specific details below regarding the error made and correction requested:

Signature of Applicant

Date