LOUISIANA STATE BOARD OF NURSING

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

REQUEST FOR ADVANCED PRACTICE REGISTERED NURSE LICENSURE IN AN ADDITIONAL APRN ROLE/POPULUATION FOCUS/SPECIALTY

This packet is to be completed only if you have already been issued an Advanced Practice Registered Nurse (APRN) license in Louisiana and you are requesting APRN licensure in an *additional* Advanced Practice role and population focus/specialty area. No additional fee is required to apply. However, you must be duly licensed by the Louisiana State Board of Nursing as an APRN in ***each*** specialty by the Louisiana State Board of Nursing prior to practicing as an APRN in Louisiana.

APPLICANT INFORMATION:

Name (Last, First, Middle and Maiden):		
Street Address:		
City:	**State:**	**Zip Code:**
*Is the above a **new** mailing address?* ☐ **- YES** ☐ **- NO**		**Home Phone:**
Email address:		**Cell Phone:**
Social Security #:	**LA RN #:**	**LA APRN #:**

INDICATE THE FOLLOWING:

AP ROLE AND POPULATION FOCUS/SPECIALTY OF NEW APRN LICENSE SOUGHT			
☐ **NP**	☐ **CNS**	☐ **CNM**	☐ **CRNA**
PROVIDE POPULATION FOCUS/SPECIALTY: (Examples FNP, ANP, PNP, WHCNP, ACNP, PMHNP-Adult, CNS-Adult, etc.)			

The following information/forms are required for licensure as an APRN in an additional advanced practice role and population focus/specialty. Please check below to indicate that you have requested the following documents from each party to be send directly to the Louisiana State Board of Nursing. Sign/date at bottom of the AP7 form and mail to LSBN.

☐ **I hold a current and valid license to practice as a Registered Nurse in Louisiana ***

☐ **I hold a current and valid license to practice as an Advanced Practice Registered Nurse in Louisiana in another AP role and population focus/specialty. *** If license(s) are inactive or delinquent, you must be reinstated before applying.

☐ **I have requested verification of Advanced Practice Education (AP2) *and* official transcripts.** Please note: An official transcript(s) must also be submitted to LSBN directly from the university for your additional advanced educational preparation with the completed AP2 form;

☐ **I have requested verification of National Certification (AP3).** Please forward the AP3 form to the certifying body you have applied for examination in the new AP role and population focus/specialty and have the completed form mailed directly to LSBN.

☐ **I have requested verification of my application to sit for National Certification Examination (AP6).** ***If*** you had not already received a temporary permit for your initial APRN license and now wish to be reviewed for a permit for this additional AP role/specialty, have your certifying body complete this form and mail directly to LSBN, and mark "yes" to the question below:

I wish to be reviewed for an APRN Temporary Permit in my new additional AP role/specialty: ☐ **Yes** **- *or* -** ☐ **No**

I anticipate employment in this AP role at: _____

Name of the Hospital/Institution/Clinic and its location - for permit request

NOTE: Upon completion of this licensure process, you will be issued a letter of notification documenting the additional Advanced Practice role and population focus/specialty area of nursing which you are entitled to practice in Louisiana. Remember to submit a new signed collaborative practice agreement signed by your collaborating physicians at your existing site/group to reflect this additional scope of practice. If seeking employment for a new group - submit a 'CHANGE OF PRESCRIPTIVE AUTHORITY' packet for Board approval of your new collaborating physicians.

_____ _____

Signature of Applicant Date

AP7

Revised: 9/99, 1/04, 3/06, 8/06, 2/08, 3/12

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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**
print name of graduate above

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:
☐ * Certificate	☐ Post Graduate	☐ Certified Nurse Midwife (CNM)
☐ * Diploma	☐ Doctorate	☐ Certified Registered Nurse Anesthetist (CRNA)
☐ Masters		☐ Clinical Nurse Specialist (CNS)
☐ Other (specify): _____		☐ Certified Nurse Practitioner (CNP)

* *Certificate or Diploma only applicable if enrolled prior to December 1995*

Provide the *specific* 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**

Revised: 9/99, 5/02, 1/04, 8/06, 10/07, 2/08, 1/09, 10/11, 3/12, 2/14

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VERIFICATION OF NATIONAL AP CERTIFICATION

PART I – APRN Applicant Information

Applicant Instructions: Fill out the **top** portion of this form and forward to your National Advanced Practice Certifying Organization for completion. The certifying organization must send either this completed form ***or*** official notification of certification **directly** to LSBN.

Name (Last, First, Middle, and Maiden)**:**		
Street Address:		
City:	**State:**	**Zip Code:**
Social Security Number:		**Date of Birth:**
Certification Number: (only applicable if already licensed in another state - Endorsement)		**Expiration Date:**
Signature:		**Date:**

PART II – Verification of National Advanced Practice Certification

Certifying Organization: Please complete the bottom portion of this form and mail **directly** to the Louisiana State Board of Nursing to the address shown above. A mailed written verification on your organization letterhead will also be accepted provided it contains the same data requested below and sent **directly** to LSBN. Please notify the LSBN APRN Department if your organization offers official verification of national advanced practice certification by direct electronic communication to Boards of Nursing.

This is to certify that the person identified above has met the requirements for Certification or recertification by the:

_____

Name of Advanced Practice Certifying Agency

As a _____

AP Role/Population Focus: CRNA, FNP, ANP, PNP, NNP, WHCNP, ACNP, PMHNP-Adult, PMHNP-Family, CNS-Adult, CNM, etc.):

_____ _____ _____

Date of Certification **Certification Number** **Recertified Through Date**

_____

Authorized Signature of Certifying Agency

_____ _____

Print or Type Name **Date**

_____ **(SEAL)**

Print or Type Title

Revised: 9/99, 4/03, 1/04, 8/06, 2/08, 10/11, 3/12

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VERIFICATION OF APPLICATION FOR NATIONAL ADVANCED PRACTICE CERTIFICATION EXAMINATION

PART I – APRN Applicant Information

Applicant Instructions: Fill out the **top** portion of this form and forward to your National Advanced Practice Certifying Organization for verification of your application to sit for the national certification examination in the AP role and population focus/specialty in which you are applying for Louisiana APRN licensure. This completed form must be submitted **directly** to LSBN.

Name (Last, First, Middle, and Maiden):		
Street Address:		
City:	**State:**	**Zip Code**:
Social Security Number:		**Date of Birth**:
Louisiana R.N. License Number:		**Expiration Date**:
Signature:		**Date**:

PART II – Verification of Application to Sit for AP Exam

Certifying Organization: Please complete the bottom portion of this form and mail **directly** to the Louisiana State Board of Nursing to the address shown above.

This is to certify that the applicant identified above has submitted an application for the national certification examination -

☐ **To be administered by:** ☐ **Has been administered by:**

_____

Name of Advanced Practice Certifying Agency

Name of Educational Institution attended: _____

Provide APRN Role *and* Population Focus/Specialty: _____

(Examples: FNP, ANP, PNP, NNP, WHCNP, ACNP, PMHNP-Adult, PMHNP-Family, CNS-Adult, CNM, CRNA, etc.)

Date of Examination: _____ Or Between _____ and _____

Results will be available within _____ weeks after date of examination.

(SEAL)

_____ _____

Authorized Signature of Certifying Agency **Date**

Revised 9/99, 6/03, 1/04, 8/06, 2/08, 10/11, 3/12