



Advanced Registered Nurse Practitioner (ARNP) Supervised Practice Application Plan

To: ARNP Applicants

From: Nursing Care Quality Assurance Commission
Department of Health
P.O. Box 47864
Olympia, WA 98604-7864

Subject: Earning practice hours through supervision, when licensing requirements are not met.

Date: December 22, 2008

These instructions are for the Advanced Registered Nurse Practitioner whose license is due for renewal, expired, inactive, or pending endorsement from another state, where the required 250 practice hours per two year renewal cycle or application date, have not been met (not to exceed 1,000 hours).

The application process is different for each circumstance; please see application on DOH website for requirements. www.doh.wa.gov

1. You must submit a written notification with preceptor agreement to the nursing commission thirty days prior to the supervision experience.
 - a. The agreement will include the name and license number of the ARNP or physician who will be supervising you. Their practice must be in the same practice area as your license. You must also include the number of hours to be completed, meeting the requirements of your licensure, or reactivation. (Please use ARNP/Physician agreement form provided by the Nursing Commission attached to this packet.)
2. During the time of the supervision, you will be practicing under your RN license and not use the designation of ARNP.
3. At the end of the supervision period, the supervisor will submit a written evaluation to the commission. (Evaluation must be on company letterhead; see example letter.)

For further detail of the rules regarding supervised practice, please see the following website: www.leg.wa.gov/legislature. The Advance Practice rules are under WAC Chapter 246-840.

Supervised Practice Notification

I, _____ am notifying the
Applicant's Name

Nursing Care Quality Assurance Commission that I will be obtaining supervised practice to meet my licensure requirements. I have included the ARNP/Physician supervising agreement listing the name of my preceptor and credential information. My circumstances for licensure are as follows:

1. I have an expired or inactive ARNP license in Washington State, but have been out of practice for _____ years.
2. I have an active ARNP license in Washington State, but did not meet my 250 practice hours within the two year renewal cycle, to be able to renew.
3. I am a first time applicant for the state of Washington, and have been licensed as an ARNP in another state. I have not been in practice for _____ years.
4. I am a first time applicant for the state of Washington with an active ARNP license in another state, but did not meet the 250 practice hours within the last two years.
5. Other: (Please explain) _____

Based on the information above, I will complete _____ hours of supervised practice by

Date

Applicant's Signature

Date



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

ARNP/Physician Supervising Agreement

Effective _____, _____, _____
Date Supervisor's Name/Title License Number

has agreed to supervise _____, _____
Applicant's Name License Number

in the role of Advanced Registered Nurse Practitioner at _____.
Name of Facility

The duration of the supervision will be _____ hours consistent with the applicant's license requirement.

The supervisor will provide no less than 250 hours, no more than 1,000 hours of supervised learning and implementation consistent with the applicant's scope of practice. At the end of the supervised period, the supervisor shall provide a written evaluation of the applicant on company letterhead. The evaluation will verify whether or not the applicant has successfully completed the required hours. If the supervision period was successful, the letter must state that the applicant's knowledge and skills are at a safe and appropriate level to practice as an ARNP.

Supervisor's Signature Date

Applicant's Signature Date

For Official use Only

Supervisor credential checked _____ Area of practice approval _____

Applicant credential checked _____ Practice site approved _____

Notification letter _____

Staff initials _____ Date _____

Example Letter
Supervised Practice Evaluation

I, _____, have completed supervising
Supervisor's Name

_____, for _____ hours of ARNP
Applicant's Name

supervised practice within his/her area of practice. I further verify that the applicant has successfully completed the required hours of supervised clinical practice and that the applicant's knowledge and skills are at a safe and appropriate level to practice as an ARNP.

Supervisor's Signature

Date

Applicant's Signature

Date

(Note: Evaluation must be on company letterhead.)