Registered Nurse by Examination Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

Contact us:

360.236.4700

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Washington State Department of Health

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly. It is your responsibility to submit the required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the fee page for current fees.

☐ **1: Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See WAC 246-12-310.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See WAC 246-12-300.

☐ **2: Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3: Professional Education:**
Check next to high school diploma or GED. List in chronological order your educational preparation and post-graduate training. If you need more space, attach a piece of paper.

☐ **4: License in Other State(s) or Country(ies)**
List all states/countries where you have held an RN or an LPN license. List these licenses in the order they were issued.

☐ **5: Other License:**
List all states, including Washington, where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.

☐ **6: AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training. This is required by **WAC 246-12-260** course content can be found in **WAC 246-12-270**.

☐ **7: Applicant's Attestation:**
You must sign and date this for us to process the application. Your signature indicates you have read and understand this section.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **http://www.doh.wa.gov/hsqa/professions/military/** and include supporting documentation with your application.

Washington State Department of Health

License Requirements

Thank you for applying to become a licensed registered nurse in Washington State. The information listed below will help to expedite the license process.

☐ **Certificate of Completion:**

- If you are a graduate of a Washington State nuring program, the director of the program will send an electronic certificate of completion to our office after you complete the program. We can make you eligible to take the NCLEX once we receive it.
- If you are a graduate from a nursing program in another state or jurisdiction, submit the paper certificate of completion that is in this packet to your program director. Have them fill it out and submit to the Nursing Commission.

☐ **Official Transcripts:**
Have your school mail your transcripts with your degree listed to the Nursing Commission. We need this to license you after you pass your NCLEX exam.

☐ **NCLEX Candidate Bulletin:**
This Bulletin will guide you through the registration process with Pearsonvue, to take your NCLEX exam. Pearsonvue is the testing agency that administers the exam. Read the Candidate Bulletin and follow the instructions. The Candidate Bulletin can be downloaded from http://www.ncsbn.org.

☐ **Time Frames:**

- From the time you mail your application to the Nursing Commission Office, it takes three-four weeks to process your application. We will not be able to assist you prior to receiving your application. Please allow enough time before calling with questions.
- Carefully read and maintain your Candidate Bulletin. It contains valuable information and telephone numbers.
- We receive results 24 hours following your exam. Once received in the Nursing Commission Office exams are processed and mailed to the candidate. Allow four weeks from test date for results in the mail. You can access our Web site to see if your license has been issued. You will receive your license in the mail 7-10 days after it's issued.
- If you fail, you will be notified by email with instructions on how to reapply with the testing company. There is a mandatory 45 day wait between tests.

If you have questions or concerns, please call 360.236.4700.

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Background Check Stamp Here

Date Stamp Here

Revenue 0258010000

Registered Nurse License Application

You must check the box next to Examination or Endorsement:

☐ Examination ☐ Endorsement

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)			☐ Male ☐ Female
Name First	Middle	Last	

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address			
City	State	Zip	County
Country			

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address	☐ Check box if you want to join nursing ListServ

Mailing address (if different from above)			
City	State	Zip	County
Country			

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

☐ AIDS	☐ COC	☐ Verif (Foreign)	☐ Scripts	☐ CGFNS	☐ TOEFL
☐ Active License	☐ Other	☐ PDQ			

☐ NCLEX Registration # ________________

License Date ______________________ License # _______________ Validation #___________________

Graduation Date ______________________ School Code ______________________

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

	Yes	No
b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐

3. Professional Education

High school graduate? ☐ Yes ☐ No

If no, GED? ☐ Yes ☐ No

Institute		Name/Location	Start Date	End Date	Diploma/Degree Granted
College	University				

4. License(s) in Other State(s) or Country(ies)

List all states/countries you have held an registered nurse license in. List these licenses in the order they were issued.

Check One		State/Country	Current Expiration Date
As RN	As LPN		

State or **country** in which originally licensed by examination. ____________________

Year license first issued ____________ as an ☐ RN ☐ LPN

Have you taken the State Board Test Pool Examination (SBTPE) or NCLEX in the United States? ☐ Yes ☐ No

If yes, state ____________________ as an ☐ RN ☐ LPN

Have you ever applied for license in Washington prior to this application? ☐ Yes ☐ No

If yes, under the name of____________ as an ☐ RN ☐ LPN Approximate date__________

5. Other License(s) (Include Previous Credentials in Washington State)

List all health care licenses held and in what state. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

State	Profession	License Type	License		Method of License
			Year issued	Number	

6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This Includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues confidentiality, psychosocial issues, and special population considerations. I understand I must maintain records documenting education for two years and be prepared to submit those records to the department if requested. **I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

7. Applicant's Attestation

I, ________________________________ , declare under penalty of perjury under the laws of the state of
Print applicant name clearly
Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated __________________in _______________________________________
City, state

By:_________________________________
Signature of applicant

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Washington State Department of Health
Nursing Commission
PO Box 47864
Olympia, WA 98504-7864
360.236.4700

(For Out-of-State Graduates Only)

Certificate of Completion of RN Program

(to be completed AFTER program completion)

I certify that the individual listed below **HAS** completed all requirements for the degree/diploma for the approved Registered Nurse program as outlined in **WAC 246-840-575**. I understand that my signature on this form will allow this individual to sit for the registered nurse licensure examination. The student has been instructed to request their official transcripts, with the degrees/diplomas posted, to be sent to the Nursing Commission as so as it is possible.

Last Name of Graduate	
First Name	Middle Name/Initial
Date of Birth	Social Security Number
Date of Program Completion	

Signature of Authorized Person

Title

Name of School of Nursing

School Seal

Dated this ______________ day of ______________________, 20 ______________

Please send completed form to:

Washington Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

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Washington State Department of Health

Health Professions Reference Numbers and Links

RCW/WAC Links

Uniform Disciplinary Act ....UDA RCW 18.130

Administrative Procedure Act ....APA RCW 34.05

Administrative procedures and requirements ....WAC 246-12

RCW Registered Nursing ....RCW 18.79

WAC Registered Nursing ....WAC 246-840

On-Line

AIDS Training ....Reference Page

Nursing Quality Assurance Commission ....Web Page