



ARNP with or without Prescriptive Authority 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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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 in blue or black ink. It is your responsibility to submit the correct forms required.

Application Fee. This fee is non-refundable. You can check the online [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: first, middle, and last.

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 credential. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with 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: Education:

List in date order your educational preparation and post-graduate training. Attach additional pages if you need more space.

4: National Certification:

Check the box that applies to your status.

- Currently nationally certified as a nurse practitioner (not clinical nurse specialist). There may be an exception for the Psychiatric Clinical Nurse Specialist. Please contact the Nursing Commission for details.
- Not currently certified but have registered for a board approved national examination

Provide the following information:

- Specialty
- Certifying body
- Recognition date

5: Pharmacology Education:

This section only needs to be filled out if applying for Prescriptive Authority.

6: Other License, Certification, or Registration:

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. Attach additional pages if you need more space.

7: AIDS Education and Training Attestation:

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in [WAC 246-12-270](#).

8: 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/hsga/professions/military/> and include supporting documentation with your application.

License Requirements

1. Have or obtain a current/active Washington RN license.
2. Provide your official transcript(s). This must come directly from the college or university where you completed your graduate degree in nursing or your advanced practice preparation and must be submitted to the Nursing Commission in a sealed envelope.
 - A minimum of one academic year is required for preparation for ARNP license. [WAC 246.840.340 \(5\)\(c\)](#).
 - If you have no graduate degree, send proof of advanced practice license or ARNP certification from another state or US territory if prior to December 31, 1994.
 - If your transcripts do not state you completed an advanced practice program, you need to request a letter from your dean or instructor in the area of specialty practice you completed.
3. Provide proof of current national certification. This must come from the certifying body.
4. If you completed the advanced practice program more than one year ago, we require proof of 250 hours of employment in the advanced practice role within the past two years. We accept proof of employment in the form of a letter on letterhead from your employer. If you do not meet practice requirements of supervised clinical practice may be required. [WAC 246.840.342/344](#).
5. If you are applying for an interim permit send all of the documentation for license, a current Washington RN license, the fee ([see fee page](#)), and a copy of the letter from the national certifying body stating you are registered for the exam.
 - An interim permit is valid until you are licensed as an ARNP, you fail the exam or you fail to take the exam.
 - The interim permit is not renewable.
 - Prescriptive authority is not granted with an interim permit.
 - The national certification organization must send a letter stating you are certified.
 - The interim permit may be issued for up to 60 days past the initial registration period.

ARNP Designations that are Recognized and Licensed by the State of Washington

An advanced registered nurse practitioner may practice independently in Washington. The national certifying body publishes and distributes the scope of practice statements. [WAC 246.840.300](#)

The Nursing Care Quality Assurance Commission approved the following national certification programs for ARNPs.

American Association of Nurse Anesthetists (AANA)	847.692.7050
American College of Nurse Midwives (ACNM).....	301.459.1321
American Nurses Credentialing Center (ANCC)	800.284.2378
Pediatric Nursing Certification Board (PNCB)	888.641.2767
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC)	800.673.8499
American Academy of Nurse Practitioners (AANP).....	512.442.4262



Background
Check
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Revenue 025804000

ARNP with or Without Prescriptive Authority Application

Check all that apply: Initial ARNP ARNP by Endorsement
 Prescriptive Authority Interim Permit

Nurse Midwife Nurse Practitioner Nurse Anesthetist

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 address of record

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 on file 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

License # _____ License Date _____

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.

- 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. Education

High school graduate? Yes No If no, GED? Yes No

List in date order your educational preparation. Attach additional pages if you need more space.

Institute		Schools Attended Full Name, City and State	Type of Degree/Diploma Earned	Attendance Dates	
College	University			Start (mm/yyyy)	End (mm/yyyy)

4. National Certification

Currently nationally certified as a nurse practitioner in the area of _____
Specialty

by _____ on _____
National certifying body Date of recognition

Not currently certified but have registered for a board approved national examination in the area of _____

_____ by _____
Specialty National certifying body

on _____
Date of recognition Exam date

5. Pharmacology Education

List in date order, 30 hours of pharmacology education you have attended during the past two years. Include pharmacokinetic principles and their clinical application and use of pharmacological agents in the prevention of illness, restorations, maintenance of health. *Note: This may have been included in your NP Program. This section only needs to be filled out if applying for Prescriptive Authority. Send in documentation of pharmacology (certificates, transcripts, etc.).

Pharmacokinetic Principles and Their Clinical Applications	Contact hours

6. Other License, Certification, or Registration

List all states (including Washington) where licenses/certifications/registrations are or were held.

State	License/Certification/Registration type	License/Certification/Registration		Method of license		
		Year issued	Number	Exam	End	GF

7. 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 to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

8. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)

Washington that 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 that 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 _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act.....	<u>UDA RCW 18.130</u>
Administrative Procedure Act	<u>APA RCW 34.05</u>
Administrative procedures and requirements.....	<u>WAC 246-12</u>
RCW Registered Nursing	<u>RCW 18.79</u>
WAC Registered Nursing	<u>WAC 246-840</u>

On-Line

AIDS Training	<u>Reference Page</u>
Nursing Quality Assurance Commission	<u>Web Page</u>