Nursing Commission
P.O. Box 47864
Olympia, WA 98504-7864
360.236.4700

Licensed Practical Nurse Foreign Trained Application Packet Contents:

1. 669-228....Contents List/SSN Information/ Mailing Information .... 1 page
2. 669-266....Application Instructions Checklist ....2 pages
3. 669-232....Additional Information and Instructions .... 1 page
4. 669-002....Licensed Practical Nurse Application ....5 pages
5. 669-235....Statement of Eligibility.. 1 page
6. RCW/WAC Links, AIDS Courses, and Online Web Sites .... 1 page

Important Social Security Number Information:

Social Security Number: 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 your check or money order payable to:

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

Send additional documents 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. It is your responsibility to submit the correct forms required.

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

☐ **Step #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 application form, your application may be denied.

Birth date: 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 applicable.

Email: Enter your email address, if applicable.

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**.

☐ **Step #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. You must include the school you are currently attending if applicable. If you need more space, attach a separate 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 to you (1st, 2nd, 3rd, etc.)

☐ **#5: Other License:**
List all states where any health care licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

☐ **#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. Read this very carefully.

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Additional Information and Instructions

Please Read this and Your NCLEX Candidate Bulletin

Persons whose nursing education was not in English must complete the TOEFL exam prior to applying for the National LPN exam in Washington State.: TOEFL—PO Box 6151—Princeton, NJ 08541-6151 609.771.7100

NCLEX-PN Candidate Bulletin:

Please carefully read and follow the directions in your Candidate Bulletin. You must mail your exam registration form, with the fee, in the enclosed, pre-addressed envelope. Mail this registration form (to the testing company) at the same time you mail your application for licensure by exam to the Washington Nursing Commission. Do Not Throw your Candidate Bulletin away until after you receive your test results. The Candidate Bulletin will tell you how to complete and file the registration form with the testing company and answer many of your questions.

Your ATT (authorization to test) comes from the testing company (ETS) not the Nursing Commission. The ATT will advise you on how to schedule yourself for the exam. Allow a minimum of four-weeks from the time you mail your application and registration before calling for information.

Results: We receive the test results approximately one-two-days after you test. We then process them and mail these results (with a license if you pass) within two-weeks of your test date. There are hundreds of test-takers every week. Please allow 4-weeks from the time you test until you receive your results in the mail.

Download the NCLEX Examination Candidate Bulletin from their Web site at **www.ncsbn.org**.

Should you fail the NCLEX-PN, you will be sent information on retesting. You have the opportunity to test a total of 4-times in a two-year period of time starting the day you graduate.

360.236.4706 for questions.

Important Information—Please Read

All applicants for LPN licensure in Washington State are required to complete an approved LPN program.

If you are a graduate of a foreign LPN nursing program, you need to have taken a socialization course for licensed practical nurses. This course is referred to as “Personal and Vocational Relationships of the Practical Nurse.”

You should contact the Nursing Commission and inquire about taking this course. Once you have completed the above course, please have the Nursing School mail verification directly to our office.

If you have any questions regarding this request or the licensing process, please contact our office at the address on your instructions.

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

Revenue 0258010000

Background Check Stamp Here

Date Stamp Here

Licensed Practical Nurse 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 ( )	Fax ( )	Cell ( )

Email address

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, mental retardation, 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. 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 to you (1st, 2nd, 3rd, etc.)

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)

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 (7) hours of education in the prevention, transmission and treatment of AIDS, which included 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 (2) 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

7. Applicant's Attestation

I,___________________________________, declare under penalty of perjury under the laws of the state
(Print applicant name clearly)
of 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 ______________________________ at ____
City/State

By: _________________________________
Original Signature of Applicant

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EXAM

Statement Of Eligibility

Last name ______________________________ First ________________________ Middle ______________

Maiden____________________________________Birth date (mm/dd/yyyy)__________________________

Address ______________________________ City ____________ state _________ zip ______________

This form is to be completed on both sides by the Director/Coordinator of the nursing program. Return directly to the Nursing Commission (address above) along with an official copy of the applicant's transcript.

I certify that ____ is currently/was enrolled in the accredited

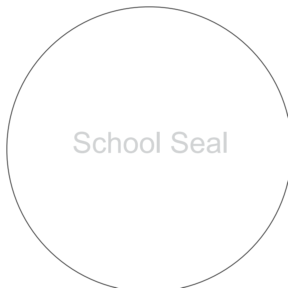
nursing program at _____________________________________ located _____________________________

in ____; and that the above is/was at time of departure in good standing. ☐ Yes ☐ No (If "No," please explain fully on the bottom of this form.)

Admission date ____Graduation date (if applicable)

The above named has completed __________________ Quarters _______ Semesters ___________ Units

Nursing Credits in the nursing program (fill in whatever blanks apply to your program), which includes the subject matter as stated on form. Please send an Official Copy of the Transcripts. NOTE: Both sides must be completed and signed by the Director/Coordinator.



____
Name

____
Title

____
Date

Send completed form and transcripts to:

Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

Please respond to each item listed

Subject Matter

	Completed	Not Completed
1. Social, behavioral and related foundation subjects		
a. Personal and Vocational Relationships of the Practical Nurse	☐	☐
b. Normal Growth and Development Through the Life Cycle	☐	☐
c. Psychology—Social Facts and Principles (May be integrated into nursing courses)	☐	☐
2. Biological and related foundation subjects		
a. Anatomy and Physiology	☐	☐
b. Elementary Concepts—Microbiology, Chemistry and Physics (check completed box if integrated into fundamentals or other courses)	☐	☐
c. Nutrition and Diet Therapy	☐	☐
d. Pharmacology and Applied Mathematics	☐	☐

Clinical Experience

	Completed	Not Completed
3. Principles and practice of practical nursing		
a. Fundamentals of nursing	☐	☐
b. Clinical pharmacology	☐	☐
c. Medical/surgical nursing	☐	☐
d. Obstetrics (pre and post partum care and care of infants)	☐	☐
e. Pediatric nursing (well and ill child)	☐	☐
f. Geriatric nursing	☐	☐
g. Mental health nursing (objectives can be met in **ANY** clinical area)	☐	☐

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Health Professions Reference Numbers and Links

RCW/WAC Links

UDA RCW 18.130 .... Uniform Disciplinary Act

APA RCW 34.05 .... Administrative Procedure Act

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

RCW 18.79 .... Licensed Practical Nursing Law

WAC 246-840 .... Licensed Practical Nursing Rules

Online

AIDS Training .... http://www.doh.wa.gov/cfh/hiv_aids/Prev_Edu/license_training.htm

Nursing Commission https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/default.htm

Required Hours of Training, WAC 246-840-360

Continuing education (CE) Training after license has been issued .... 30 hours /every two years

Pharmacotherapeutics related to licensee's scope of practice is
required if you have prescriptive authority .... 15 hours