



Advanced Registered Nurse Practitioner Application Packet

Contents:

1. 669-220Contents List/SSN Information/Mailing Information..... 1 page
2. 669-258Application Instructions Checklist.....3 pages
3. 669-209Advanced Registered Nurse Practitioner Requirements..... 1 page
4. 669-099Advanced Registered Nurse Practitioner Application.....5 pages
5. RCW/WAC and Online Website Links 1 page

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, please read, complete, and return this [form](#) with your application.

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
P.O. Box 1099
Olympia, WA 98507-1099

Send supporting documents not mailed with initial application to:

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

Contact us:

360-236-4703

(This page intentionally left blank.)

Application Instructions Checklist

FBI background check information: Washington State Law authorizes the Department of Health to obtain fingerprint background checks for licensing purposes. This check is done through the Washington State Patrol and the Federal Bureau of Investigation (FBI).

- You **will** be required to submit fingerprints for the background check if you have an out of state address listed on this application. (Not out of country).
- You **must** obtain your fingerprints on the Department of Health fingerprint card.
- Once we receive your application **we will send** you the fingerprint packet with instructions on how to complete the process.
- A temporary practice permit will be issued if all other licensing requirements are met pending the completion of this process.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

Application Fee. This fee is non-refundable. You can check the online [fee page](#) for current fees.

Select if the following applies:
Spouse or Registered Domestic Partner of Military Personnel

Check appropriate box for method of licensure; Exam or Endorsement

1. Demographic Information:

Social Security Number: You must list your social security number on your application. If you do not have a social security number please read, complete, and return this [form](#) with your application.

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 about 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: List your phone, fax and cell numbers.

Email: Provide your email address. **Email is our primary form of communication.** Your email address is required. Join our [Listserv](#) to receive update and news from the Nursing Commission.

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 certified documentation referencing 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 may obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction refers to any other country, state, federal territory, or military authority.

3. Professional Education:

List your current or completed nursing program. Indicate degree/certificate/diploma earned. List graduation or anticipated graduation date. Attach additional completed pages if you need more space.

4. National Certification:

Check the box that applies to your status.

- a. Currently nationally certified as a nurse practitioner or a clinical nurse specialist.
- b. Not currently certified but have registered for a board approved national examination.

Provide the following information:

- Specialty
- Certifying body

5. Endorsement/Employment Verification:

Provide employment verification of 250 hours of advanced nursing practice within the last two years. List all US states that you are currently practicing as an ARNP.

6. Requesting Prescriptive Authority:

Prescriptive authority attestation must be initialed and dated if you choose to obtain prescriptive authority. See [Pain Management](#).

7. Pharmacology Education:

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

8. 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](#). If AIDS education was included in your professional education or training, an additional course is not required.

9. Applicant's Attestation:

You must sign and date your application for it to be valid. Your signature indicates that you have read and understood this section. Your signature must be **original**. We will not accept the application if your signature is photocopied or has an electronic signature.

Please note: If we require additional documentation, we'll let you know by email. Please avoid calling to check the status of your application. This allows program staff to process your application file with fewer interruptions.

- The application is incomplete if requested information is left blank. Fill in N/A or place a line through the section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See [WAC 246-12-020\(3\)](#).
- Please review [continued competency requirements](#) for renewal.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
 - A copy of your marriage certificate to show proof of marriage; or
 - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

(This page intentionally left blank.)

Advanced Registered Nurse 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.
3. Provide proof of current national certification. **This must come directly from the certifying body.**
4. Provide employment verification of 250 hours of advanced nursing practice within the last two years. This is not required if you have graduated less than one year prior to applying. [WAC 246.840.342/344](#).

Acceptable forms of documentation:

- Letter from employer on employers letterhead stating you have completed 250 hours in advanced nursing practice within two years.
- Pay stubs with ARNP title and add up to 250 hours within two years.
- Pay stubs without credential must include contact and position description.

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 approves the following national certification programs for.

American Academy of Nurse Practitioners (AANP).....	512-637-0500
American Association of Critical-Care Nurses (AACN)	800-899-2226
American Association of Nurse Anesthetists (AANA).....	847-692-7050
American Midwifery Certification Board (AMCB)	866-366-9632
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
Oncology Nursing Certification Corporation (ONCC)	877-769-6622

(This page intentionally left blank.)

Date
Stamp
Here

Revenue 0258010000

Advanced Registered Nurse Practitioner Application

Check all that apply: ARNP by Examination ARNP by Endorsement/Reciprocity
 Clinical Nurse Specialist Nurse Anesthetist (CRNA) Nurse Midwife (CNM) Nurse Practitioner (NP)

Select if the following applies: Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Male
 Female

Social Security Number (SSN) (If you do not have a SSN, see instructions)

Name	First	Middle	Last
------	-------	--------	------

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

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

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

Email address

Mailing address if different from above address of record

City	State	Zip Code	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

COC Received
Review for: FBI HIPBB WSP PDQ NOD
 Approved per policy A21.05 delegated decision making for selected license applications
 Forward to CMT Approved by CMT Denied by CMT

Proceed with licensing process _____
Signature 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

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?
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?

3. Professional Education

Current or Completed Nursing Program	Name/Location of Nursing Program	Anticipated Graduation Date	Certificate/Diploma/Degree Granted
			<input type="checkbox"/> ADN
			<input type="checkbox"/> BSN
			<input type="checkbox"/> MSN
			<input type="checkbox"/> Post-Masters Certificate
			<input type="checkbox"/> DNP
			<input type="checkbox"/> Other

4. National Certification

Currently nationally certified as a nurse practitioner or clinical nurse specialist in the area

of _____ by _____
Specialty National certifying body

on _____
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 _____
Exam date

5. Endorsement/Employment Verification

Please include:

Employment Verification of 250 hours of advanced nursing practice in two years.

List the states in the US you are currently practicing as an: ARNP CNS

6. Requesting Prescriptive Authority

I do not want prescriptive authority.

I am requesting prescriptive authority.

I certify I have read the 2011 rules that govern the use of opioids for treatment of chronic non-cancer pain.

Applicant's Initials	Date

7. Pharmacology Education

Please complete this section if you are applying for Prescriptive Authority. If you graduated within the last two years and you completed an advanced pharmacology course, this meets the requirements.

I have attached 30 hours of Continuing Education in pharmacology completed within the last two years. Evidence must show pharmacology hours earned.

8. 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.

If you have meet the requirement, you must initial and date this section.

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.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's Initials	Date

9. 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 have read all laws and rules related to my profession.

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: _____
(Original signature of applicant)

(This page intentionally left blank.)

RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Nursing Care Laws, RCW 18.79](#)

[Nursing Care Rules, WAC 246-840](#)

[How To Return To Active Status From Expired Status, WAC 246-12-040](#)

Online

[AIDS Training Resources, Reference Page](#)

[Nursing Commission, Web Page](#)

New Rules: Use of Opioids for treatment of Chronic Non-Cancer Pain

[Chronic Non-Cancer Pain, WAC 246-840](#)

For CE and what qualifies, pay particular attention to sections

- [WAC 246-840-490](#) Consultation-Exemptions for the advanced registered nurse practitioner.
- [WAC 246-840-493](#) Pain management specialist.

For additional sources currently on the web follow the directions below. Start at the nursing commission [web page](#).

Click on [Pain Management Rules](#). This is the centralized place for all the prescribers that are affected by the new rule.