Registered Nurse by Endorsement Application

Contents:

1. Contents List/SSN Information/Mailing Information/RCW/WAC and Online Website Links
2. License Requirements
3. Registered Nurse Application
4. Non-NURSYS® License Verification

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.

This disclosure is mandatory, based on section 466(a)(13) of the Social Security Act [42 U.S.C. 666(a)(13)], and will be used under the State’s child support enforcement program to locate individuals for the purposes of establishing paternity and establishing, modifying, and enforcing support obligations.

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

In order to process your request:

Mail your application with your check or money order payable to:
Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send supporting documents not mailed with your application to:
Nursing Commission
P.O. Box 47864
Olympia, WA 98504-7864

Contact us:
Phone: 360-236-4703
E-mail: Nursing@doh.wa.gov

RCW/WAC Links
Uniform Disciplinary Act, RCW 18.130
Administrative Procedure Act, RCW 34.05
Administrative Procedures and Requirements, WAC 246-12
Nursing Laws, RCW 18.79
Nursing Rules, WAC 246-840
Registered Nurse License Requirements by Endorsement

*Important notice. New licensure requirement.

After you verify your Washington State nursing license is active on the Department of Health’s Provider Credential Search you must enroll with E-Notify on NURSYS.com to complete the registration process. Enroll at https://fortress.wa.gov/doh/opinion/s?s=WorkforceData and select “As a Nurse” to complete the registration process. By enrolling in Nursys® e-Notify, you can take advantage of a quick, convenient and free way to keep up-to-date with your nursing license(s). You can receive licensure status updates, track license verifications for endorsement and manage multiple license expiration reminders. Keeping on top of your license can help prevent any fraudulent licenses or certificates being issued in your name.

FBI background check information: Washington State law authorizes the Department of Health to obtain fingerprint background checks for licensing purposes. The Department of health completes the check through the Washington State Patrol and the Federal Bureau of Investigation (FBI).

- If you have an out-of-state address on your application, you are required to complete an FBI fingerprint background check (not out of country). The FBI charges a fee for the background check.
- You must obtain your fingerprints on the Department of Health fingerprint card sent to you once we receive your application.
- A temporary practice permit will automatically be issued if all other licensing requirements are met pending the completion of this process.

1. Application and Fee: You must submit a completed Registered Nurse by Endorsement application with fee. Check the online fee page for current fees. The application fee is non-refundable.

2. RN License (verification of license by examination): On www.nursys.com, follow directions to verify your original license by examination to Washington. There is a fee you will pay to NURSYS® for this service. To prevent delays, complete NURSYS verification before sending your application. If your original state of license does not participate with NURSYS®, either send the Non- NURSYS verification form in this application packet to that board of nursing or see its website for its online verification request instructions. You need to follow directions on their website or contact their office for the instructions, fee, and processing time.

3. English Proficiency Examination: An English proficiency test is required for all LPN and RN license applicants who received their nursing education outside of the United States except for Canada (Quebec nursing education requires the English proficiency test), United Kingdom, Ireland, Australia, New Zealand, (Samoa, Guam, Mariana Islands and Virgin Islands). You must take and pass either the: WAC 246-840-045
   - Test of English as a Foreign Language (TOEFL) www.toefl.com
   - International English Language Testing System (IELTS, academic version) www.ielts.org

This examination is required regardless of whether the program was taught in English.

- Passing TOEFL scores for RN applicants: a total score of 83 with a speaking score of 26; institution code is 7292.
- Passing IELTS scores for RN applicants: a total score of 6.5 with a score of 6.0 in the following areas; listening, reading, writing, and speaking.

If you were educated in countries not listed above, you may have the English proficiency exam waived if you can provide evidence of working as an RN in another U.S. state for 1,000 hours or more. Have the current or past U.S. employer submit verification on letterhead confirming your employment. The verification must include the number of hours practiced as an RN.
4. **Proof of a current/active RN License:** If your license from your original state of licensure is not current or active, we need proof of a current or active license. If you have an active license from a state that participates with NURSYS®, we can obtain license information. If you do not have a current or active license with a NURSYS® participating state, see the state website where your license is active. Print the page showing a current or active license. Send this proof of with your application.

5. **NCLEX:** If you obtained your nurse education outside the United States, Washington State requires you to pass the NCLEX-RN. If you do not have a license in another state or you have not taken the NCLEX-RN exam, please see our website for the correct application.

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## Important Additional Information

1. You will receive a one-time paper license in the mail seven to ten working days after issued. You may access our website to verify your license information using the Provider Credential search.

2. It is your responsibility to renew your RN license annually up to 90 days prior to your birthday regardless if you receive your renewal notice.

3. 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).

4. **Name change requirement:** If you applied for a nurse or healthcare license in Washington state through the Washington State Department of Health and have since changed your name, we require a copy of the legal name change document submitted with your application. (such as a marriage certificate, divorce decree, or other court documents)

5. **Change of address requirement:** If your address changes, you must update it with the Washington State Department of Health. You will need to send in the following information to Nursing@doh.wa.gov: your credential number, your full name, and your new address.

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### 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 service member of any branch of the U.S. Military, including Guard or Reserve, and apply for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to quickly receive your credential.

Submit the following documents with your application:

- A copy of your spouse’s or registered domestic partner’s military transfer orders to Washington State.

**And 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

**Note:** If we require additional documentation, we notify you by the e-mail address you provide on your application.
# Registered Nurse License by Endorsement Application

If we do not receive all required documentation within 30 days your application may be closed as incomplete resulting in you having to reapply and pay the application fee again.

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

## 1. Demographic Information

- **Male**
- **Female**
- **Other**

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

Name (First, Middle, Last):

Birth date:  
E-mail address:

Address:

City:  
State:  
Country:

ZIP code:  
Phone number:  
County:

**Note:** The mailing and e-mail addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the Nursing Commission.

Have you ever been known under any other name(s)?  
If yes, list name(s):

Will documents be received in another name?  
If yes, list name(s):

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## For Office Use Only

Review for:  
☐ FBI  
☐ NPDB/NURSYS  
☐ WSP  
☐ PDQ  
☐ NOD

☐ Approved per policy A21.07 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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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..........................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Condition</strong> 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.</td>
<td></td>
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</tr>
<tr>
<td>If you answered yes to question 1, explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. How your treatment has reduced or eliminated the limitations caused by your medical condition.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.</td>
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<td></td>
</tr>
<tr>
<td><strong>Note:</strong> If you answered “Yes” to question 1, the Nursing Commission 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 Nursing Commission 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 Nursing Commission. 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 Nursing Commission, your application may be denied.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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. ..................................................</td>
<td></td>
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<tr>
<td><strong>Currently</strong> means within the past two years.</td>
<td></td>
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<tr>
<td><strong>Chemical substances</strong> include alcohol, drugs, or medications, whether taken legally or illegally.</td>
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<td></td>
</tr>
<tr>
<td>3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ..........................................................</td>
<td></td>
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</tr>
<tr>
<td>4. Are you currently engaged in the illegal use of controlled substances? ..........................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Currently</strong> means within the past two years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Illegal use of controlled substances</strong> 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> If you answer “Yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. 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. The department does criminal background checks on all applicants.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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? .........................</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Personal Data Questions (cont.)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Have you ever been found in any civil, administrative or criminal proceeding to have:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Diverted controlled substances or legend drugs?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Violated any drug law?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. Prescribed controlled substances for yourself?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

“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.

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

<table>
<thead>
<tr>
<th>Name of Nursing School</th>
<th>Location of Nursing School</th>
<th>Graduation Date</th>
<th>Certificate/Degree Granted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ ADN/ASN ☐ BSN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Diploma ☐ MSN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ ADN/ASN ☐ BSN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Diploma ☐ MSN</td>
</tr>
</tbody>
</table>

4. Original State of Licensure by Examination

State originally licensed by examination: ________________________________ (NCLEX or SBTPE)
5. 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.** If AIDS education was included in your professional education or training, an additional course is not required.

**NOTE:** If you have met the requirement, you must initial this section. If you feel you need this training you can find a list of trainings at [HIV/AIDS Training for Licensure](#).

6. Applicant’s Attestation

I, __________________________________________ , declare under penalty of perjury under the laws of the state 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 have read all laws and rules related to my profession.

I understand the Nursing Commission may require more information before deciding on my application. The Nursing Commission 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 Nursing Commission of any past, current or future criminal charges or convictions. I will also inform the Nursing Commission 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 Nursing Commission information on my health, including mental health and any substance abuse treatment.

By:_________________________________________ Dated ___________________________

(Original signature of applicant) (mm/dd/yyyy)
Non-NURSYS® License

Verification of Original Licensure by Examination

Please complete the top portion of this form and forward to your licensing authority (board) if it does not participate with NURSYS®. (Please contact that board for fee and processing time.)

<table>
<thead>
<tr>
<th>Select a License:</th>
<th>Registered Nurse (RN)</th>
<th>Licensed Practical Nurse (LPN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number:</td>
<td></td>
<td>Previous last name used:</td>
</tr>
<tr>
<td>Name (First, Middle, Last):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
<td>ZIP Code:</td>
</tr>
<tr>
<td>Original State Licensed:</td>
<td>License Number:</td>
<td></td>
</tr>
<tr>
<td>Name as it appears on original license:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I hereby authorize the release of my license data to the Washington State Nursing Commission.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature ____________________________ Date _______________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This portion to be completed by original licensing authority (Board) and mailed to Washington.

<table>
<thead>
<tr>
<th>Examination:</th>
<th>NCLEX</th>
<th>State Board Test Pool Exam</th>
<th>Date Passed</th>
<th>RN</th>
<th>LPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current License Status:</td>
<td>Active</td>
<td>Not active</td>
<td>Expiration Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has this license ever had disciplinary action?</td>
<td>Yes</td>
<td>No</td>
<td>(if yes, attach explanation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disciplinary action pending?</td>
<td>Yes</td>
<td>No</td>
<td>(if yes, attach explanation)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of Nursing School Completed:

State/Province of School: |
Graduation date: |

Type of Nursing Program: Certificate Diploma ADN/ASN BSN MSN

<table>
<thead>
<tr>
<th>Signature</th>
<th>State</th>
<th>Date</th>
</tr>
</thead>
</table>

DOH 669-218 January 2019