# Advanced Registered Nurse Practitioner License Reactivation 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, 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
How To Return To Active Status From Expired Status, WAC 246-12-040

## Advanced Registered Nurse Practitioner Reactivation Requirements

**In accordance with WAC 246-840-365 and 367, the following must be met to reactivate an expired or inactive nurse practitioner license:**

1. **Application and Fee:** You must submit a completed ARNP reactivation application with fee. You can check the online fee page for current fees. This fee is non-refundable.
2. **A current/active Washington RN license**. You may apply at the same time.
3. **Verification of current national certification** with your application.
4. **Documentation of continuing education (CE)** 30 hours of general CE within the past two years.
5. **For prescriptive authority**, documentation of an additional 30 pharmacology CE hours within the past two years.
   - If you practiced in another U.S. state with prescriptive authority within the last two years and can provide evidence of it, you may request an exemption to the pharmacology CE requirement listed in WAC 246-840-410
6. **Employment verification** of 250 hours of advanced clinical nursing practice within the past two years. If you do not meet the requirements of 250 hours of advanced practice see Section 4 of the application

# Additional Important 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, your credential number, your full name, and your new address.

**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, 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

**Note:** If we require additional documentation, we will notify you by e-mail.

For Official Use Only

Date Stamp Here

Revenue 0258010000

# ARNP License Reactivation 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<br>○ Female<br>○ Other | **Social Security Number (SSN)** :<br>(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)? ☐ 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

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

Washington State Department of Health

## 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:

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

| | | |
|---|---|---|
| 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. 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.

| | | |
|---|---|---|
| 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? | ☐ | ☐ |

Washington State Department of Health

## 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? | ☐ | ☐ |

"**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.

| | Yes | No |
|---|---|---|
| 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. Advanced Clinical Practice

☐ I completed 250 hours of advanced clinical practice within the past two years.

**Note:** Evidence of clinical practice is required (For example, letter from employer, payment statements with title)

## 4. Supervised Advanced Clinical Practice

☐ I have not completed the required 250 hours of advanced clinical practice. I request to complete supervised practice. ARNP Supervised Practice Application Packet (PDF)

## 5. Requesting Prescriptive Authority

☐ I do not want prescriptive authority.

☐ I request prescriptive authority.

☐ I certify I read the 2018 rules that govern the use of opioids for treatment of chronic non-cancer pain. (required for prescriptive authority) Chronic Non-Cancer Pain, WAC 246-840-460 to 246-840-4990

☐ I attached 30 hours of continuing education in pharmacology completed within the past two years. Evidence must show pharmacology hours earned. (form)

☐ I completed 250 hours of advanced clinical practice with prescriptive authority within the past two years and request an exemption to the 30 hours of continuing education in pharmacology. I included evidence with the application. (Prescriptive authority in the other state must be equivalent to Washington to include independent practice and ability to prescribe schedule II-V)

## 6. Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.
I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

Applicant's Initials

## 7. AIDS Education and Training Attestation

I certify I 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 Nursing Commission 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

**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.

## 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 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)