ARNP Expired License Activation 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.
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 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:
360-236-4703
Application Instructions Checklist

All information should be typed or printed clearly in blue or black ink.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

☐ Pay Late Renewal Fee.
☐ Pay Current Renewal Fee.

All fees are 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. 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: Enter your phone, fax and cell numbers, if you have them.

   Email: Enter your email address. Email is our primary form of communication. Get important information about your credential by subscribing to email alerts.

   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. Other License, Certification, or Registration:
List all licenses you have held since last being licensed in Washington State. List in date order, most current first. Include your last active licensed in Washington State. Attach additional completed pages if you need more space.


☐ 5. Applicant’s Attestation: Required to be both signed and dated in order to process the application.

Additional Information

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

1. Obtain a Current RN license in Washington State.
2. Provide evidence of current national certification.
3. Provide documentation of an additional 30 contact hours of continuing education in the area of specialty during the last two years. If reactivating with prescriptive authority, please provide documentation of 30 contact hours in pharmacology continuing education hours within the last two years. Please use this form to document hours.
4. Provide evidence of 250 hours of advanced clinical practice during the last two years.
5. If unable to provide evidence of advanced clinical practice, please see our website for instructions on obtaining supervised practice.

Note:
You will be notified in writing if more documentation is needed. Please try to avoid calling to check on the status of your application. This will allow 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 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).
**ARNP Expired Credential Activation Application**

Please type or print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could result in a delay in processing your application. Make sure you have read and understand the instructions.

### 1. Demographic Information

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Social Security Number (If you do not have a social security number, see instructions)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td></td>
</tr>
</tbody>
</table>

**Name**

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<thead>
<tr>
<th></th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

**Birth date (mm/dd/yyyy)**

**Place of birth**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Country</th>
</tr>
</thead>
</table>

**Address**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

**Country**

**Phone (enter 10 digit #)**

**Fax (enter 10 digit #)**

**Cell (enter 10 digit #)**

**Email address:**

**Mailing address if different from above address of record**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
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</table>

**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)?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>If yes, list name(s):</td>
<td></td>
</tr>
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</table>

**Will documents be received in another name?**

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If yes, list name(s):</td>
<td></td>
</tr>
</tbody>
</table>

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**For Office Use Only**

**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
<table>
<thead>
<tr>
<th>2. Personal Data Questions</th>
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<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>
</tr>
<tr>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>“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.</td>
</tr>
<tr>
<td>If you answered yes to question 1, explain:</td>
</tr>
<tr>
<td>1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.</td>
</tr>
<tr>
<td>1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.</td>
</tr>
<tr>
<td><strong>Note:</strong> 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.</td>
</tr>
<tr>
<td>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.</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>
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<td><strong>Yes</strong></td>
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<tr>
<td>“Currently” means within the past two years.</td>
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<tr>
<td>“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.</td>
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<td>3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?</td>
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<tr>
<td><strong>Yes</strong></td>
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<td>4. Are you currently engaged in the illegal use of controlled substances?</td>
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<tr>
<td><strong>Yes</strong></td>
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<tr>
<td>“Currently” means within the past two years.</td>
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<tr>
<td>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.</td>
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<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. The department does criminal background checks on all applicants.</td>
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<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>
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<tr>
<td><strong>Yes</strong></td>
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<tr>
<td><strong>Note:</strong> 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.</td>
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<td>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.</td>
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2. Personal Data Questions (cont.)

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? .................................................................

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

3. Previous Credentialing (Include Previous Credentials in Washington State)

<table>
<thead>
<tr>
<th>State/Jurisdiction</th>
<th>Profession RN or ARNP</th>
<th>Credential Number</th>
<th>Year Issued</th>
<th>Check the Method of Credentialing</th>
<th>License is Active?</th>
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<td>Exam</td>
<td>No Yes</td>
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<td>Endorsement</td>
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4. 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.

5. Applicant's Attestation

I, ____________________________, declare under penalty of perjury under the laws of the state of Washington 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 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)
RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, UDA RCW 18.130
Administrative Procedure Act, APA RCW 34.05
Administrative procedures and requirements, WAC 246-12
Nursing Care Laws, RCW 18.79
Nursing Care Rules, WAC 246-840
ARNP Rules, WAC 246-840-365 and 246-840-367
How To Return To Active Status From Expired Status, WAC 246-12-040

On-Line

AIDS Training Resources, Reference Page
Nursing Commission, Web Page