FOR OFFICE USE ONLY		
Eligible to Test		
BCI Attached?	☐ Yes	☐ No
Retake?	☐ Yes	☐ No
Receipt #		
ID #		
Issue Date		
License #		

Rhode Island
Board of Nurse Registration and Nursing Education

Room 105
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

License As A

☐ **Registered Nurse**
☐ **Licensed Practical Nurse**

By Examination

Applicant - Print Name (First/MI/Last)

Phone: (401) 222-5700 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-3352**

Revised 09/23/2011 jcp

GENERAL INFORMATION

VERY IMPORTANT

Rhode Island is part of the Nurse Licensure Compact. If your legal residence is in a state that is part of the Nurse Licensure Compact, you must apply for that state's license, which will provide you privileges to work in RI. You do not need a RI nursing license. Please visit https://www.ncsbn.org/158.htm in order to determine if your state is part of the Compact. Your employer just needs to verify your nursing license by visiting https://www.nursys.com .

If your legal residence is in a state that is not part of the Nurse Licensure Compact and you wish to practice nursing in RI, then you must obtain a RI nursing license by completing this application.

For more information regarding the Nurse Licensure Compact, please visit our website at:

http://www.health.ri.gov/for/nurses/

Enclosures

The following materials and information should be enclosed within this application packet:

Application Process Overview.....3

Instructions for Completing Application.....4

Application Materials

Application.....5-8

Application Checklist.....9

Voluntary Race/Ethnicity Questions.....10

Licensure Requirements

U.S. Graduates

- Fee of **$130.00** for Registered Nurse, **$90.00** for Licensed Practical Nurse.
- Recent passport type photograph.
- Official transcript from the school of nursing listing graduation date and degree.
- Graduation from a nursing program.
- Attach a FULL Bureau of Criminal Identification (BCI) Check. **PLEASE NOTE:** Your application **WILL NOT BE ACCEPTED WITHOUT THE BCI CHECK ATTACHED** to this application.
- Copy of evidence of primary address (eg. copy of driver's license, tax return, etc...)

Foreign-Trained Nurses

- Requirements listed under U.S. Graduates.
- Completion of the requirements of the **Commission of Graduates of Foreign Nursing Schools**.
- Copy of evidence of primary address (eg. copy of driver's license, tax return, etc...)

Note: Information regarding the CGFNS can be obtained at its web site. **www.cgfns.org/cgfns/index.html**

90-day Graduate Nurse License

- Non-renewable under any circumstances, and are issued only **once** .

GENERAL INFORMATION - CONTINUED

Rules and Regulations

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

http://www.health.ri.gov/atoz/

National Council of State Boards of Nursing (NCSBN) and NCLEX Examination Information:

111 East Wacker Drive, Suite 2900, Chicago, IL 60601-4277 - Testing Services Toll-Free: (866) 293-9600

NCSBN Testing Services: (312) 525-3750 FAX: (312) 279-1036

Web Site: **http://www.ncsbn.org** Email: nclexinfo@ncsbn.org

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation, and the Rhode Island Board of Nurse Registration and Nursing Education (Board).

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 9) must be submitted for an application to be considered complete. All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year a new application must be submitted.

If you have a criminal history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received, and a decision to be made regarding issuance of your license.

https://healthri.mylicense.com/Verification/

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing. Be advised, you may be required to appear for an interview. NOTE: You may ***not*** practice in Rhode Island until you have received a license number.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-5700.

Please Note: Your application will not be accepted or processed without a FULL Bureau of Criminal Identification (BCI) check attached. Rhode Island residents are required to obtain this information via the RI Attorney General's Office, 150 South Main Street, Providence, RI 02903 Tel. (401) 421-5268. Out-of-state applicants must obtain a Full BCI check from their state of residence.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application pages (5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages MUST clearly indicate the section for which such information is being reported.
2. Attach the BCI Check to this application. NOTE: Your application WILL NOT be accepted or processed without the BCI Check attached.
3. Attach a copy of evidence of primary address (eg. copy of driver's license, tax return, etc...)
4. Make a check or money order (in U.S. Funds only) for the application fee of **$130.00** (for RN), or **$90.00** (for LPN) payable to **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NONREFUNDABLE.
5. Complete all application materials as instructed and arrange them in the order listed on the application checklist (page 9). Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

Rhode Island Department of Health
Board of Nurse Registration and Nursing Education
Room 105, 3 Capitol Hill
Providence, RI 02908-5097

In addition to the materials you mail to HEALTH, the following must be either mailed or requested from other sources.

1. Official transcript from the school of nursing must be submitted by the college/school/university, directly to the Board, at the address listed above. ***Fascimiles will not be accepted.*** This transcript includes the date of completion, graduation, and degree.

State of Rhode Island
Board of Nursing Registration and Nursing Education

Application for License as a RN/LPN by Examination

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address Please check ONE	☐ Please use my **Home Address** as my preferred mailing address ☐ Please use my **Business Address** as my preferred mailing address
8. Qualifying Education Please list the name and information about the school that you attended which led to your licensure as a nurse.	Type of School (University, College, Trade/Technical School etc.) Name of School State Date Graduated: Month Day Year Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.) Major ☐ U.S Graduate ☐ Foreign Graduate
9. NCLEX Exam Please provide information about any attempts at the NCLEX exam.	Have you ever applied for, or taken, the NCLEX examination in another state/territory? ☐ Yes ☐ No If yes; provide name of state/territory:
10. Authorization for release of Exam Score: Authorization for the Board of Nurse Registration & Nursing Education to release NCLEX examination scores to your school of Nursing.	I hereby authorize the Board of Nurse Registration & Nursing Education to release my NCLEX examination scores to my school of nursing. ☐ Yes ☐ No

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month Year

12. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

1. Are there any charges or investigations pending, in any state, against you? ☐ Yes ☐ No

2. Have you ever had any disciplinary action(s) taken, or is any pending against your license to practice nursing, or any other licenses, registrations or certifications that you hold; or are any complaints pending in any state? ☐ Yes ☐ No

Note: If you answered "yes" to any of these questions you must explain below or, if needed, on a separate sheet of paper.

13. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Nurse Registration and Nursing Education any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as nurse in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Nurse Registration and Nursing Education of any change in the answers to these questions after this application and this affidavit is signed.

_____ Signature of Applicant

_____ Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ Name of Notary (Print, Type or Stamp)

_____ Signature of Notary

Notary Seal

_____ Notary No/Commission No.

_____ Commission Expiration Date (MM/DD/YY)

14. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

Affix Photo Here

Write your name on the back of the photograph, and provide the date that the photograph was taken.

_____ Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the Rhode Island Board application as instructed (pages 5-8).
- ☐ I have attached the cover page of the application.
- ☐ I have completed Section 13, **"Affidavit of Applicant"**, and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 14, **"Recent Photograph"** as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the ***"RI General Treasurer"*** in the amount of **$130.00** (for RN) or **$90.00** (for LPN) and attached it to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- ☐ I have arranged my Board Application materials in the following order.

  1. Fee (attached as instructed).
  2. Board Application (including cover page) (pages 5-8)
  3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application] MUST indicate the section for which the information is being reported.]

- ☐ I have mailed the above application materials directly to the Rhode Island Board of Nurse Registration and Nursing Education.
- ☐ I have enclosed evidence of my primary residence such as a copy of my driver's license, tax return, etc...

Other Documents

- ☐ I have requested a school transcript as instructed.
- ☐ I have attached the FULL Bureau of Criminal Identification (BCI) check, obtained from the RI Attorney General's Office to this application.

Applicant: Print your complete last name >

State of Rhode Island and Providence Plantations
Department of Health

This information is completely voluntary and will NOT affect your Application in any way.

VOLUNTARY RACE/ETHNICITY QUESTIONS*

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

1. Ethnicity: Are you Hispanic or Latino? (Mark **"No"** if **not** Hispanic or Latino.)

☐ No, not Hispanic or Latino ☐ Yes, Hispanic or Latino

2. Race: What is your race? (Mark one or more.)

☐ American Indian or Alaska Native ☐ Black or African American ☐ White
☐ Asian ☐ Native Hawaiian or other Pacific Islander

For the purposes of the above questions kindly use the "Federal Minimum Data Collection" explanations listed below:

1. Ethnic Categories:

Hispanic or Latino

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."

Not Hispanic or Latino

A person who is not Hispanic or Latino.

2. Racial Categories:

American Indian or Alaskan Native

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan , Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American

A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American".

Native Hawaiian or Other Pacific Islander

A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

*This information is being collected in accordance with the Department of Health's Policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.