

**REQUIREMENTS FOR RECOGNITION - ADVANCED PRACTICE REGISTERED NURSES
APPLYING FOR RECOGNITION IN THE STATE OF HAWAII**

Access this form via website at: www.hawaii.gov/dcca/areas/pvl

(This is not an application for **Prescriptive Rights**)

INSTRUCTIONS FOR FILING

**APPLICANTS
FOR APRN
RECOGNITION**

REGISTERED NURSES WHO HOLD A CURRENT, UNENCUMBERED LICENSE IN THE STATE OF HAWAII, may apply for initial recognition by submitting the following:

- *1. An official transcript of the **master's degree in nursing** from an accredited or approved school must be sent **DIRECTLY** to the Board from your nursing school; **OR**
- *2. Verification of current certification in the nursing specialty sent **DIRECTLY** to the Board from the national certifying body recognized by the Hawaii Board of Nursing or approved by the American Board of Nursing Specialties (www.nursingcertification.org/categories_regular.html). Please contact your organization and have them send verification of your current status. See list of recognized certifying bodies on attached application; **AND**
3. Verification of unencumbered license as a registered nurse **and** as an APRN or similar designation in all states in which you are **CURRENTLY** licensed. Use form (*NSG-28*), if applicable. This form may be duplicated.

NOTE: If you are applying for initial recognition **AND** your Hawaii Registered Nurse license at the same time, be advised that each application has its own application and license fees and supporting documents.

*Advanced graduate nursing preparation that focus on direct care to individuals which require regulatory recognition are nurse practitioners, clinical nurse specialists, certified nurse anesthetists, and certified nurse midwives. Other advanced graduate nursing preparation that do not focus on direct care to individuals (e.g. informatics, public health, education, or clinical systems management/administration) are not recognized.

**APPLICATION
FORM**

1. Type or print *legibly* in dark ink.
2. Answer **all questions**. If not applicable, write N/A.
3. Sign application.

- **Failure to provide all the requested information will delay the processing of your application.**

If you are applying for more than one specialty, be sure to have the appropriate documentation (Master's degree or current certification) sent **directly** to the Board for **each** specialty. Incomplete applications will not be accepted and will be returned for completion. Failure to complete the licensing requirements within two (2) years, will void your application (436B-9, HRS).

**SOCIAL SECURITY
NUMBER**

Your social security number is used to verify your identity for licensing purposes and for compliance with the below laws. **For a license to be issued you must provide your social security number or your application will be deemed deficient and will not be processed further.**

The following laws require that you furnish your social security number to our agency:

FEDERAL LAWS:

42 U.S.C.A. §666(a)(13) requires the social security number of any applicant for a professional license or occupational license be recorded on the application for license; and

If you are a licensed health care practitioner, **45 C.F.R., Part 61, Subpart B, §61.7** requires the social security number as part of the mandatory reporting we must do to the Healthcare Integrity and Protection Data Bank (HIPDB), of any final adverse licensing action against a licensed health care practitioner.

HAWAII REVISED STATUTES ("HRS"):

§576D-13(j), HRS requires the social security number of any applicant for a professional license or occupational license be recorded on the application for license; and

§436B-10(4) HRS which states that an applicant for license shall provide the applicant's social security number if the licensing authority is authorized by federal law to require the disclosure (and by the federal cites shown above, we are authorized to require the social security number).

ADDRESS

The Board's mailing address is:

*Hawaii Board of Nursing
P.O. Box 3469
Honolulu, HI 96801*

OR

Deliver to office location:

*Hawaii Board of Nursing
335 Merchant St., Room 301
Honolulu, HI 96813
Phone: (808) 586-3000*

FEES

Make check payable to: *COMMERCE AND CONSUMER AFFAIRS*

	<u>Fee</u>
If license will be issued between JULY 1, ODD-NUMBERED years (2007, 2009) and JUNE 30, EVEN-NUMBERED years (2008, 2010), pay	\$140
(Application - \$40**, License - \$20, Compliance Resolution Fund --\$70***, ½ renewal – \$10)	

*If license will be issued between JULY 1, EVEN-NUMBERED years (2008, 2010) and JUNE 30, ODD-NUMBERED years (2009, 2011), pay	\$ 95
(Application - \$40**, License - \$20, Compliance Resolution Fund - \$35***)	

- If you are eligible for a license near the end of the second year of a two-year license period (within 3 months), you may elect to delay the issuance of your license until July 1, odd-numbered year, **provided you do not intend to start practicing your trade or profession until the next license period.**

NOTE: One of the numerous legal requirements that you must meet in order for your new license to be issued is the payment of fees as set forth in this application. You may be sent a license certificate before the payment you sent us for your required fees is honored by your bank. If your payment is dishonored, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a \$25.00 service charge shall be assessed for payments that are dishonored for any reason.

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.

* *If you select this option, your license will be subject to renewal by June 30, Odd numbered year – REGARDLESS of issue date.*
 ** *Application fee is not refundable.*
 *** *The Compliance Resolution Fund (CRF) was established by the 1982 Legislature (§26-9(m), HRS, to expedite resolution of consumer complaints filed with the Department of Commerce and Consumer Affairs. Assessment amounts are based on the services rendered in resolving complaints. Assessment is due for the issuance of a new license as well as for the renewal of a license.*

ADDITIONAL SPECIALTIES

Once you are licensed as an Advanced Practice Registered Nurse (APRN) and wish to add another specialty, you will need to complete this application. No additional fee is required. An official transcript of the master's degree in nursing **OR** verification of current certification in the nursing specialty must be sent **DIRECTLY** to the Board. You will not be required to submit verification of an unencumbered license again, unless changes have occurred since your last application. Your request is subject to Board ratification/approval.

ABANDONMENT OF APPLICATION

Pursuant to HRS §436B-9 your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years. The failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit any required information and documents requested by the licensing authority within two consecutive years from the last date the documents and information were requested, or (2) failure to complete any additional requirements for licensure that remain after approval of your application, such as attempting to complete an exam requirement, within two consecutive years from the date your application was approved, or (3) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process. If an application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

NOTIFICATION OF DISCIPLINARY ACTION

Once recognized, the APRN is responsible for notifying the Hawaii Board of Nursing of any disciplinary action taken against any nursing license/APRN recognition in any other state or U.S. jurisdiction within 30 days of the action. Failure to do so may result in action against the nurse's Hawaii APRN recognition and nurse's license.

STATE LAWS AND RULES

All applicants/licensees are responsible for reading, being knowledgeable and maintaining current knowledge of the Hawaii Statutes and Rules relating to nursing and the amendments adopted throughout the years for the duration of the applicant/licensee's nursing career. Copies are available by submitting a written request to the Board.

- a. Chapter 457, Hawaii Revised Statutes, Nurses.
- b. Chapter 89, Hawaii Administrative Rules, Nurses.
- c. Chapter 436B, Hawaii Revised Statutes, Professional & Vocational Licensing Act.

The laws and rules are also posted on our website at: www.hawaii.gov/dcca/areas/pvl. Click on "Nursing". Then click on "Statute/Rule Chapter" to the right.

ADDRESS/NAME CHANGES

It is the responsibility of the applicant to notify the Board of any changes **in writing**. If you have a name change **after** your application was originally filed, you must provide a photocopy of the name change document along with a letter requesting the change. All address changes must be submitted **in writing**. No changes will be accepted over the phone. The Board will not be responsible for non-receipt of any correspondence.

LICENSE RENEWALS

All nursing licenses and APRN Recognition, **regardless of issue date**, expire on June 30 of each odd-numbered year (2007, 2009) and are subject to renewal. Your Registered Nurse license and APRN Recognition both require a separate renewal form and fees. An APRN Recognition cannot be renewed unless the RN license is renewed.

- a) APRNs who were recognized initially by their MSN degree shall submit:
 - 1) Renewal application; and
 - 2) Fees.
- b) APRNs who were recognized initially by national certification shall submit:
 - 1) Renewal application;
 - 2) Fees; and
 - 3) Proof of current certification.

All certified nurse midwives shall meet the renewal requirements of (b).

AT NO TIME MAY A NURSE, WHOSE LICENSE HAS LAPSED, CONTINUE TO PRACTICE AS A NURSE. IT IS THE NURSE'S DUTY TO INFORM EACH EMPLOYER WHO IS IMPACTED, OF THE NURSE'S FAILURE TO RENEW A NURSING LICENSE ON TIME.

ADVANCED PRACTICE REGISTERED NURSES WITH PRESCRIPTIVE AUTHORITY (APRN-Rx)

Contact the Department of Commerce and Consumer Affairs at (808) 586-3000 for a separate application, or you may download the application from: www.hawaii.gov/dcca/areas/pvl.

Note: The requirements for APRN with Prescriptive - Authority require both a Master's Degree in Nursing and current national certification. Therefore, if you intend on filing for Prescriptive Authority in the near future, you may elect to request your school of nursing send two (2) transcripts to the Board and your national certifying organization send two (2) verifications of current status to the Board at one time.

APPLICATION FOR APRN RECOGNITION

(This is not an application for prescriptive rights.)

Read the attached instructions before completing this form. Print Legibly.

Legal Name (First, Middle)	(LAST)
Other Names Used (include maiden name)	
Residence Address (Include Apt. No., City, State and Zip Code) - REQUIRED	
Mailing Address (ONLY if different from above)	
Social Security No.	Phone No. (days)
	Hawaii RN Lic # RN - If none, date applied:

OFFICE USE ONLY

Approved	Initials/date
[] Master's Degree transcript	[] National Certification
Date Eff.	Lic No. APRN -
RN - Exp date: 6/30/_____	Specialty Code:

Circle one:	List all states which you are CURRENTLY licensed as an RN: _____ (Contact each state to have verification sent to Board)
Initial APRN Recognition	List all states which you are CURRENTLY licensed as an APRN: _____ (Contact each state to have verification sent to Board)
Additional specialty APRN No. _____	

Indicate your APRN pathway:

via Master's degree.

• date requested transcripts: _____

via National Certification.

• date requested certification: _____

Check APRN specialties and subspecialties* applying for:

- _____ **NURSE PRACTITIONER (NP)**
- _____ Adult NP
 - _____ Gerontological NP
 - _____ Pediatric NP
 - _____ Acute Care NP
 - _____ School NP
 - _____ Neo-Natal NP
 - _____ Women's Health Care NP
 - _____ Family NP
 - _____ Psychiatric Mental Health NP
 - _____ Family Health NP
 - _____ Community Mental Health NP
 - _____ Ambulatory Care NP
 - _____ Advanced Diabetes Management NP
 - _____ Advanced Oncology Certified NP

- _____ **CLINICAL NURSE SPECIALIST (CNS)**
- _____ Gerontological CNS
 - _____ Medical-Surgical CNS
 - _____ Community Health CNS
 - _____ Adult Psychiatric & Mental Health CNS
 - _____ Child & Adolescent Psychiatric & Adult Mental Health CNS
 - _____ Maternal - Child CNS
 - _____ Pain-Management CNS
 - _____ Community Mental Health CNS
 - _____ Critical Care CNS
 - _____ Adult CNS
 - _____ Family/Child CNS
 - _____ Parent-Child CNS
 - _____ Pediatric CNS
 - _____ Oncology CNS
 - _____ Advanced Diabetes Management CNS
 - _____ Child & Adolescent Psychiatric & Mental Health CNS

_____ **NURSE ANESTHETIST**

_____ **CERTIFIED NURSE MIDWIFE**

*Specialties and subspecialties shall focus on direct care to individuals. (Informatics, public health, education, or clinical systems management/administration are not recognized.)

App.....	433.....	\$40
Lic	436.....	\$20
CRF.....	439.....	\$35/\$70
1/2 Ren	430.....	\$10
Service Charge	BCF.....	\$25

(Continued on Back)

APPLICATION FOR APRN RECOGNITION

EDUCATION	Name and Location (city/state)	Dates (mo/yr)		Degree Earned
		From	To	
	APRN SPECIALTY PROGRAM			
	Nursing School where you received highest degree			

Are you currently certified by a National Certifying Organization? (circle one) YES NO

- American Nurses Credentialing Center
- National Certification Board of Pediatric Nurse: Practitioners/Nurse
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- American College of Nurse-Midwives
- American Association of Nurse Anesthetists
- American Academy of Nurse Practitioners
- Council on Certification of Nurse Anesthetists
- Oncology Nursing Certification Corporation
- National Association of Pediatric Nurse Associates and Practitioners

ALL APPLICANTS	Circle answers and give details when required:		
	1) Are you at least 18 years of age?	YES	NO
	2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the United States?	YES	NO
	3) In the past twenty years, have you ever been convicted of a crime for which the conviction has not been annulled or expunged?	YES	NO
	<i>If "YES", arrange to have certified court documentation on the date, place, violation for each conviction And fulfillment of conditions of each sentence sent directly to the Board.</i>		
	4) Has any license ever been revoked, suspended, or otherwise subject to disciplinary action by another state board?	YES	NO
<i>If "YES", arrange to have certified documents from each state in which disciplinary action was taken sent directly to the Board. (Include Findings of Fact, Conclusion of Law, Recommended Order, Final Order, and whether you have been re-instated. If re-instated, date and conditions of license.)</i>			
5) Are you presently being investigated or is any disciplinary action pending against you?	YES	NO	
<i>If "YES", specify all states where action was or may be imposed. Arrange to have certified documents from each state in which disciplinary action or investigation occurred or is pending against you sent directly to the Board.</i>			
<i>Note: All applications may be subject to Board review. Additional information may be requested for the purpose of clarification.</i>			
6) Do you hold or have you ever held an APRN Recognition license in Hawaii?	YES	NO	
<i>If "YES", give license number: _____ Expiration date: _____</i>			

AFFIDAVIT OF APPLICANT:

I hereby certify that the statements, answers, and representations made in this application and in the documents attached are true and correct. I understand that any misrepresentation is grounds for refusal to grant or subsequent revocation of license and is a misdemeanor (Section 710-1017, Sections 436B-19 and 457-12, Hawaii Revised Statutes). I further certify that I have read and will abide by the provisions of Hawaii Revised Statutes, Chapter 457 and Hawaii Administrative Rules, Chapter 89 and 436B.

_____ Date _____ Signature of Applicant

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

VERIFICATION OF RN/APRN LICENSE - (Applicant Applying for APRN Recognition)

Access this form via website at: www.hawaii.gov/dcca/areas/pvl

A P P L I C A N T	<p>APPLICANT: Complete top of this page and forward to state of license. (NOT HAWAII) Contact your state board for any fees associated with processing your verification. NURSUS will not verify your APRN license, so you must send this form to each state to verify each APRN license.</p>		
	Name (LAST)	FIRST, Middle	Other names used (include maiden name)
	Address (Include Apt. No., City, State and Zip Code)		Social Security No.
	Phone No.		Type of Registration:
	LICENSE NUMBER	DATE ISSUED	REGISTERED NURSE ADVANCED PRACTICE REGISTERED NURSE
<p>I hereby authorize the nursing licensing agency in the State of _____ to furnish to the Department of Commerce and Consumer Affairs, State of Hawaii, the information below.</p> <p>Date _____ SIGN HERE: _____</p>			
L I C E N S I N G A G E N C Y O N L Y	<p>This is to certify that the above-named individual was issued the following:</p>		
	<p><input type="checkbox"/> REGISTERED NURSE LICENSE (complete only if active license is maintained) Date of Issuance: _____</p>		
	<p>Licensed by: <input type="checkbox"/> examination <input type="checkbox"/> endorsement <input type="checkbox"/> waiver</p>		
	<p>Current license status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed</p>		
	<p>Has this license ever been encumbered in any way (revoked, suspended, limited, placed on probation)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(If yes, please submit certified documents relating to disciplinary action of this license including Findings of Fact, Conclusions of Law, Recommended Order, Final Order, and whether license has been restored, reinstated, or new license issued)</p> <p>Date license expires: _____</p>		
<p><input type="checkbox"/> ADVANCED PRACTICE REGISTERED NURSE (complete only if active license is maintained) Date of Issuance: _____</p>			
<p>Has this license ever been encumbered in any way (revoked, suspended, limited, placed on probation)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(If yes, please submit certified documents relating to disciplinary action of this license including Findings of Fact, Conclusions of Law, Recommended Order, Final Order, and whether License has been restored, reinstated, or new license issued)</p> <p>Date license expires: _____</p>			
<p>SEAL</p>			
<p>Signature _____</p> <p>Title _____</p> <p>State _____</p> <p>Date _____</p>			
<p>TO THE BOARD: Return this form <u>directly</u> to the Hawaii Board of Nursing.</p>		<p>DUPLICATE AS NEEDED</p>	