APPLICATION - ADVANCED PRACTICE REGISTERED NURSE PRESCRIPTIVE AUTHORITY (APRN-RX)

Read the instructions before completing this form. Print legibly or type.

OFFICE USE ONLY		
Approval date	Ineligible	Initial
Date Effective:	Recognition No. RX -	
RN - Exp 6/30/_____ APRN - Exp 6/30/_____		
Category Code:		

Legal Name (First, Middle)	(Last)	
Other Names Used (Include maiden name)		
Residence Address (Include Apt. No., City, State & Zip Code) - **REQUIRED**		
Mailing Address (Only if different from above)		
Social Security Number	Hawaii APRN Recognition No. APRN -	Effective date of Hawaii Recognition
Phone No. (Daytime)	Board of Nursing Approved Specialty/Code:	
Hawaii RN License No. RN -		

Check answers and provide details when required:

1. Have you arranged for an official transcript of a master's degree in clinical nursing or nursing science, be sent directly from the school to DCCA? ..... ☐ Yes ☐ No

   Name of school: _____ Graduation date: _____ Date requested: _____

2. Have you arranged for verification of current certification in your practice specialty, be sent from a national certifying body recognized by the Hawaii Board of Nursing to DCCA? ..... ☐ Yes ☐ No

   Name of certifying body: _____ Date requested: _____

3. Which one of the following have you successfully completed within the three-year period immediately preceding this application AND have you enclosed verification of such successful completion from your educational institution or national certifying body?

   a. ☐ At least 30 contact hours*, as part of a master's degree program from an accredited college/university, of advanced pharmacology education, including advanced pharmacotherapeutics that is integrated into the curriculum? ..... ☐ Yes ☐ No

   OR

   b. ☐ At least 30 contact hours* of advanced pharmacology, including advanced pharmacotherapeutics, from an accredited college/university? ..... ☐ Yes ☐ No

   OR

   c. ☐ At least 30 contact hours* of continuing education from a Hawaii Board of Nursing approved recognized certifying body, in advanced pharmacology, including advanced pharmacotherapeutics related to your practice specialty? ..... ☐ Yes ☐ No

   Name of school/provider: _____

**Contact hours means a minimum of fifty minutes of actual organized instruction. Academic credit shall be converted to contact hours as (1) one quarter academic credit = 10 contact hours, or (2) one semester academic credit = 15 contact hours.*

(CONTINUED ON PAGE 2)

App.	700	$50
RX fee.	705	$20
CRF.	712	$35/$70
1/2 Ren.	706	$20
Service Charge.	BCF	$25

4. 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

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 DCCA.

5a. List all states in which you are currently recognized or licensed as an APRN-RX:

State: _____ No. _____ Expiration date: _____

State: _____ No. _____ Expiration date: _____

State: _____ No. _____ Expiration date: _____

b. Has any of the above prescriptive authority, recognition, or licenses ever been revoked, suspended, or otherwise subject to disciplinary action? . . . . . ☐ Yes ☐ No

If "YES", arrange to have certified documents from the state in which disciplinary action was taken, sent directly to DCCA. (Include Findings of Fact, Conclusion of Law, Recommended Order, Final Order, and whether you have been reinstated. If re-instated, date and conditions of license.)

c. Are you presently being investigated or is any disciplinary action pending against any of the licenses, prescriptive authority, recognitions, certifications, or registrations you hold? . . . . . ☐ Yes ☐ No

If "YES", arrange to have certified documents from the state in which disciplinary action or investigation is pending against you, sent directly to DCCA.

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 recognition and is a misdemeanor (Section 710-1017, Sections 436B-19 and 457-12, Hawaii Revised Statutes). I also certify that I have read, understand, and agree to comply with Chapters 89 and 89C, Hawaii Administrative Rules for Advanced Practice Registered Nurse practice and APRN Prescriptive Authority.

_____ Signature of Applicant

_____ Date

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.