

Office of Professional Regulation  
 Vermont Board of Nursing  
**Advanced Practice Registered Nurse Endorsement Application**

2x2 Recent Photo- Paste Here	Application Fee: \$75.00
Passport sized photo of head and shoulders taken within the last 6 months.	Office Use Only

**Directions:**

Enclose a check or money order in the amount indicated, payable to "Office of the Secretary of State". **This application fee is non-refundable.**

You must complete each section of this form. **Please print clearly.**

**Section A:**

Name: _____			
(Last)	(First)	(Middle)	(Former/Maiden)
Mailing address: _____			
(Street & P.O. Box)			
_____			
(City)	(State)	(Zip Code)	

Note: It is unprofessional conduct for a licensee to fail to notify the Secretary of State's Office of a change of name or address within thirty (30) days (3 V.S.A. § 129a(a)(14)).

If your 911 address is different from your mailing address, please indicate the 911 address here:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy): _____
Social Security # _____ - ____ - _____	Place of Birth (city, state, country): _____

\*\*\* Providing your social security number (SSN) is mandatory, and requested under the authority granted by 42 U.S.C. §405(c)(2)(C). It will be used by the Departments of Taxes, Child Support, Labor and the Judiciary in the administration of Vermont law, to identify individuals affected by such laws. Your SSN is not disclosed as part of a public records request.

Home Telephone: _(____)_____	Cell Phone: _(____)_____
Work Phone: _(____)_____	E-Mail Address: _____

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**Section B:**

Please answer yes or no to each of these questions. If the answer is yes please follow the provided instructions.

Have you ever committed any acts or omissions which are grounds for disciplinary action such as those resulting in denial, conditions, revocation or limitations in hospital privileges? <i>If "Yes", provide a detailed written explanation and attach all related documents.</i>	Yes	No
Have you ever committed acts of abuse, neglect, or misappropriation of patient property? <i>If "Yes", provide a detailed written explanation and attach all related documents.</i>	Yes	No
Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) ever denied your application for a license, certificate, or registration in any profession or occupation? <i>If "Yes", attach an official copy of the order or official notification of the action.</i>	Yes	No
Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) ever restricted, suspended, revoked, or taken any other disciplinary action against a license, certificate, or registration that you hold or held in any profession or occupation? <i>If "Yes", provide an official copy of the order or official notification of the action.</i>	Yes	No
Have you ever surrendered a license, certificate, or registration to a licensing authority? <i>If "Yes", provide a detailed written explanation.</i>	Yes	No
Are you currently under investigation by another licensing authority? <i>If "Yes", provide a detailed written explanation and a copy of any available information from the licensing authority.</i>	Yes	No
Have you ever been convicted of a crime other than a minor traffic violation? (Driving While Intoxicated and Driving Under the Influence are <u>not</u> minor) <i>If "Yes", provide a detailed written explanation and attach the official certified court documents.</i>	Yes	No
Do you have any criminal charges pending against you in any jurisdiction (US or elsewhere)? <i>If "Yes", provide a detailed written explanation and attach a copy of the charges.</i>	Yes	No
Do you have a physical or mental condition or disorder which in any way impairs or limits your ability to practice this profession with reasonable skill and safety? <i>If "Yes", please have your provider submit a detailed statement explaining how you are able to practice safely.</i>	Yes	No
Does your use of alcohol, drugs, or medications in any way impair or limit your ability to practice this profession with reasonable skill and safety? <i>If "Yes", provide a detailed written explanation.</i>	Yes	No
Are you currently addicted to or in any way dependent on, the use of alcohol or habit forming drugs? <i>If "Yes", provide a detailed written explanation.</i>	Yes	No
Are you currently participating in a supervised program or professional assistance program which monitors you in order to assure that you are not engaging in the use of alcohol or controlled substances? <i>If "Yes", please provide the contract/stipulation under which you are practicing.</i>	Yes	No

Note: It is unprofessional conduct for a licensee to fail to report to the Office of Professional Regulation a conviction of any felony or any offense related to the practice of the profession in a Vermont district court, a Vermont superior court, a federal court, or a court outside Vermont within 30 days (3 V.S.A. § 129a(a)(11)).

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**Section C:**

**CHILD SUPPORT:**

Child Support Orders (15 V.S.A. § 795)

As of the date of this application: (you must check one)

- I am not subject to a child support order; OR
- I am subject to a child support order and am in good standing\* or in full compliance with a plan to pay
- I am not in good standing or in full compliance with a plan to pay.\*\*

**TAXES:**

Tax Compliance (32 V.S.A. § 3113(b)):

As of the date of this application: (you must check one)

- I have never lived or worked in Vermont and do not owe Vermont taxes; OR
- no taxes are due and payable and all required returns have been filed; OR
- the liability for any taxes due and payable is on appeal; OR
- I am in compliance with a payment plan approved by the Vermont Department of Taxes; OR
- I am not in good standing\* or in full compliance with a plan to pay.\*\*

**UNEMPLOYMENT COMPENSATION:**

Unemployment Compensation (21 V.S.A. §1378(b)):

As of the date of this application: (you must check one)

- This does not apply to me because I am not now, nor have I ever been an employer in Vermont; OR
- No contributions or payments in lieu of contributions are due and payable; or the liability for any contributions or payments in lieu of contributions due and payable is on appeal; or the employing unit is in compliance with a payment plan approved by the commissioner; OR
- I am not in good standing\* or in full compliance with a plan to pay.\*\*

**DISTRICT COURT FINES / JUDICIAL BUREAU:**

Unpaid Judgments (4 V.S.A. § 1110(c))

As of the date of this application: (you must check one)

- I do not have any unpaid judgments.
- I am in good standing\* with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.
- I am not in good standing.\*

\* "Good standing" is defined by various laws cited above. For more information, refer to the statute or consult the "information for applicants" on the Office of Professional Regulation web page ([www.vtprofessionals.org](http://www.vtprofessionals.org)).

\*\* You may request that the licensing authority find that requiring immediate payment of child support due and payable would impose an unreasonable hardship. This form is available on the Office of Professional Regulation web page.

**Section D:**

VT RN License Number _____	Expiration Date: _____ (mm/dd/yyyy)
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**Section E:**

<b>If you have completed a MASTER's program, provide the name and location.</b>	Name
City	State
<b>Area of Study:</b> _____ <b>Date Awarded:</b> _____ mm/dd/yyyy	



**Position # 1 (most recent)**

Name of Employer: \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

Employers  
Mailing Address: \_\_\_\_\_  
(Street/PO Box)

\_\_\_\_\_  
(City) (State) (Country) (Zip/Postal Code)

Supervisors Name \_\_\_\_\_ Title: \_\_\_\_\_

Supervisors Telephone Number (\_\_\_\_) \_\_\_\_\_ Email address: \_\_\_\_\_

Job Title: \_\_\_\_\_ Paid or Volunteer \_\_\_\_\_

Full Time or Part Time: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

**Position # 2**

Name of Employer: \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

Employers  
Mailing Address: \_\_\_\_\_  
(Street/PO Box)

\_\_\_\_\_  
(City) (State) (Country) (Zip/Postal Code)

Supervisor's Name \_\_\_\_\_ Title: \_\_\_\_\_

Supervisor's Telephone Number (\_\_\_\_) \_\_\_\_\_ Email address: \_\_\_\_\_

Job Title: \_\_\_\_\_ Paid or Volunteer \_\_\_\_\_

Full Time or Part Time: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

4. If you practiced as an advanced practice registered nurse in a private duty capacity or as a volunteer, attach:

**Private Duty:**

1. An Official letter from the Attending Provider on their letter head, stating that APRN care was required.  
The letter must clearly list the Providers name, title, contact telephone number and have their signature.
2. A letter from your Employer or Client, verifying your role and duties as a Private Duty Nurse Practitioner. They must verify the number of days, hours and dates worked. The letter must clearly list the Employer/Clients name, contact telephone number, email address, mailing address and have their signature.

Volunteer:

1. An Official letter from your Employer sent directly to the Vermont Board of Nursing office from the Director of Nursing or Director of Human Resources. A copy of your Job Description as a Volunteer APRN, and a letter listing the number of days, hours and dates worked. The letter must clearly list the name of the Director of Nursing or Director of Human Resources, their telephone number, email address, mailing address and have their signature.
5. If you have completed an APRN Refresher Course please attach a photocopy of your certificate of completion as well as the re-entry program curriculum, including total theory and clinical hours.

Name of APRN Re-entry/Refresher program: \_\_\_\_\_

Date APRN Re-entry/Refresher program completed: \_\_\_\_\_  
(MM/DD/YYYY)

**Section G: Required Enclosures**

- Official copy of your transcripts released to you in a sealed envelope by the school from which you graduated. **Copies and unofficial transcripts will not be accepted.**
- This transcript must indicate successful completion of the following courses: Advanced Pathophysiology, Advanced Assessment and Pharmacotherapeutics
- Submit a copy of your current national advanced nursing practice specialty certification
- Practice guidelines must be the original, signed and dated by you and collaborating provider - if you are in the transition to practice period.
- If you do **not** require a Collaborative provider, practice guidelines must still be the original, signed and dated by you.
- Submit the APRN Attestation of Completion of Transition to Practice form if you have fulfilled the required hours.

**Copies and non-current practice guidelines will not be accepted.**

**Practice guidelines are required prior to employment.**

See *APRN Practice Guidelines Template* on Board of Nursing website for guidance in crafting your practice guidelines: [http://vtprofessionals.org/opr1/nurses/advanced\\_practice\\_registered\\_nurses.asp](http://vtprofessionals.org/opr1/nurses/advanced_practice_registered_nurses.asp)

Note - Practice guidelines must be approved by the Board prior to employment or change in clinical role, population focus or specialty.

**Section H:**

Once your license as an APRN has been approved, a new license will be sent to you. Your RN license will be placed on inactive status.

**Statement of Applicant**

I certify, under the pains and penalties of perjury, that all information I have provided in this application is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application for licensure/certification/registration. (The maximum penalty for perjury is fifteen years in prison and/or a \$10,000 fine. 13 VSA §2901.)

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Signature of Applicant \_\_\_\_\_ Date: \_\_\_\_\_

Please send completed application and fee to:  
Attn: Board of Nursing  
Office of Professional Regulation  
National Life Building, North, Floor 2  
Montpelier, VT 05620-3402  
[www.vtprofessionals.org/opr1/nurses](http://www.vtprofessionals.org/opr1/nurses)

Office of Professional Regulation  
Vermont Board of Nursing

**Advanced Practice Registered Nurse  
Attestation Form  
Completion of Transition to Practice Requirement**

**\* Fill out and submit one form for each certification you hold. On each form, indicate whether you have practiced the required number of hours to fulfill the transition to practice requirement (2400 hours and two years for primary credential; 1600 hours and 1 year for secondary credential)**

Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_\_

License #: \_\_\_\_\_

Certification: \_\_\_\_\_  
(eg: FNP, ANP, PNP, CNM, CRNA,  
PMHNP (family, adult, child/adolescent);  
Psychiatric CNS (family, adult. child/ adolescent)

Date certification first issued: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(month / year)

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Total Number of collaborative practice hours completed: \_\_\_\_\_

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Dates of practice that led to completion of transition to practice hours:  
\_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**\*I certify under the pains and penalties of perjury, that all information I have provided in this document is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in action against me. (The maximum penalty for perjury is fifteen years in prison and/or \$10,000 fine. 3 V.S.A. §2901)**

Signed: \_\_\_\_\_  
Signature Date

\_\_\_\_\_  
PRINT name of signature

Send completed form to: Vermont Board of Nursing  
Office of Professional Regulation  
National Life Building, North, Floor 2  
Montpelier, VT 05620-3402