

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

2x2 Recent Photo- Paste Here	Application Fee: \$0.00
Passport sized photo of head and shoulders taken within the last 6 months.	Office Use Only

**Directions:**

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

**I certify that I will limit my practice to providing pro bono services at a free or reduced fee clinic in Vermont. Yes \_\_\_\_\_ No \_\_\_\_\_**

**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: ___ Male ___ 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)

**Section E:**

Advanced Nursing Practice Program(s): attach additional sheets as necessary

Name of Program \_\_\_\_\_

Street Address / P.O. Box \_\_\_\_\_

Town/City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Were you awarded a Certificate? Yes \_\_\_\_\_ No \_\_\_\_\_ Were you awarded a Degree? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Degree/Certificate \_\_\_\_\_ Date of Graduation \_\_\_\_\_

mm/dd/yyyy

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Did your program include: Advanced Assessment Yes \_\_\_ No \_\_\_  
 Advanced Pharmacotherapeutics Yes \_\_\_ No \_\_\_  
 Advanced Pathophysiology Yes \_\_\_ No \_\_\_

If applying for endorsement in psychiatric/mental health, the courses must include Advanced Psychopathology instead of Advanced Pathophysiology.  
 Advanced Psychopathology Yes \_\_\_ No \_\_\_

How many supervised clinical hours were included in your program? \_\_\_\_\_

What was the clinical specialty focus of your program? \_\_\_\_\_

**Section F:**

Do you hold national certification? \_\_\_ Yes \_\_\_ No  
 If yes, complete below and include a photo copy of your current certification.  
 (if you hold more than one National Certification, attach additional sheets and include all information requested)

Name of National Certifying Organization: \_\_\_\_\_

Certification Type (APRN Specialty): \_\_\_\_\_ Expiration Date \_\_\_\_\_  
 mm/dd/yyyy

**Section G: Temporary Permit**

A temporary permit to practice as an APRN applicant may be issued after program completion. This permit remains valid until receipt of certification examination results.

I am requesting a temporary permit to practice as an APRN Applicant. Yes \_\_\_ No \_\_\_

If yes, complete the following. If no, move on to section H.

I understand that my temporary permit to practice as an APRN Applicant allows me to practice only when supervised by a preceptor who currently holds an unencumbered Vermont license as an APRN or a physician in an appropriate specialized field who is on the premises of the employing institution and is specifically assigned the responsibility of supervising me. Yes \_\_\_ No \_\_\_

If you have not taken your certifying exam or have not received certification exam results, complete the following:

Preceptor's Name \_\_\_\_\_ Credential \_\_\_\_\_ Credential Number \_\_\_\_\_

Preceptor's Practice Location (specific location where provider sees patients)  
 \_\_\_\_\_  
 (Institution name and physical location)

Preceptor's Mailing address(if different than address of practice location)  
 \_\_\_\_\_

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Date of certifying examination \_\_\_\_\_  
 mm/dd/yyyy

Copy of certifying examination registration enclosed? Yes \_\_\_ No \_\_\_

Are you requesting Prescriptive Authority? Yes \_\_\_ No \_\_\_

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**Section H: 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 (if applying for endorsement in psychiatric/mental health, the courses must include Advanced Psychopathology instead of Advanced Pathophysiology).
- Submit a copy of your current national advanced nursing practice specialty certification (or if applying for a temporary permit, a copy of your certification examination registration).
- Submit practice guidelines that are mutually agreed upon with the collaborating physician. This document must be the original, signed and dated by you and the physician. **Copies and non-current practice guidelines will not be accepted.**
- Practice Guidelines must include:
  - Description of clinical practice, including practice site(s), focus of care, and general category of clients.
  - Indexed copy of standards for clinical practice including method of data collection, assessment, plan of care, and criteria for collaboration, consultation and referral, including emergency referral
  - The name of at least one physician who holds an unencumbered license in Vermont, who practices in the same specialty area who will be routinely utilized for collaboration, consultation and referral.
  - Methods of quality assurance.
- Letter from organization at which you are providing pro bono services verifying that your practice is limited to the provision of pro bono services as an APRN.

Practice guidelines must be approved by the Board.

**Section I:**

Once your endorsement 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)

6/23/09