



**Section B: Vermont Mandatory “Good Standing” Declarations**

**CHILD SUPPORT:**

<b>Child Support Orders (15 V.S.A. § 795(c)): As of the date of this application: (you must check one)</b>	
<input type="checkbox"/>	I am not subject to a child support order; OR
<input type="checkbox"/>	I am subject to a child support order and am in good standing* or in full compliance with a plan to pay; OR
<input type="checkbox"/>	I am not in good standing* or in full compliance with a plan to pay.*

**TAXES:**

<b>Tax Compliance (32 V.S.A. § 3113(b)): As of the date of this application: (you must check one)</b>	
<input type="checkbox"/>	I have never lived or worked in Vermont and do not owe Vermont taxes; OR
<input type="checkbox"/>	No taxes are due and payable and all required returns have been filed; OR
<input type="checkbox"/>	The liability for any taxes due and payable is on appeal; OR
<input type="checkbox"/>	I am in compliance with a payment plan approved by the Vermont Department of Taxes; OR
<input type="checkbox"/>	I am not in good standing* with the Vermont Department of Taxes or in full compliance with a plan to pay.

**UNEMPLOYMENT COMPENSATION:**

<b>Unemployment Compensation (21 V.S.A. §1378(b)): As of the date of this application: (you must check one)</b>	
<input type="checkbox"/>	This does not apply to me because I have never been an employer in Vermont; OR
<input type="checkbox"/>	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
<input type="checkbox"/>	I am not in good standing* or in full compliance with a plan to pay.

**DISTRICT COURT FINES / JUDICIAL BUREAU:**

<b>Unpaid Judgments (4 V.S.A. § 1110(b&amp;c)): As of the date of this application: (you must check one)</b>	
<input type="checkbox"/>	I do not have any unpaid judgments
<input type="checkbox"/>	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; OR
<input type="checkbox"/>	I am not in good standing.*

\* “Good standing” is defined in the statutes cited above. For more information, refer to the relevant statute specific to the particular question.

**Section C: Vermont Mandatory Credential and Fitness Questions**

Please circle **Yes** or **No** for each of these questions. If the answer is **Yes** follow the provided instructions.

**Since you were originally licensed (and this is your first renewal), or since you completed your last renewal application:**

Have you 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
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Have you committed 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 documentation from the hospital.</i>	Yes	No
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Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) denied your application for a license, certificate, or registration in any profession or occupation? <i>If "Yes," attach a copy of the order or official notification of the action.</i>	Yes	No
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Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) 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 a copy of the order or official notification of the action.</i>	Yes	No
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Have you surrendered a license, certificate, or registration to a licensing authority? <i>If "Yes," provide a detailed written explanation.</i>	Yes	No
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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
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Have you been convicted of a crime other than a minor traffic violation? (Driving While Intoxicated and Driving Under the Influence are not minor) <i>If "Yes," provide a detailed written explanation and attach the official certified court documents.</i>	Yes	No
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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 charging documents.</i>	Yes	No
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**Note: Vermont law requires that you report to the Office of Professional Regulation, a felony conviction or any conviction of a crime related to the practice of your profession; within 30 days. 3 V.S.A. § 129a(a)(11).**

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
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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
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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
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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
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FINAL APRN Renewal Form 2011 0623 - March 2011

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

**Section D: Advanced Practice Registered Nurse (APRN) Education Program Requirements**

As of the date of this application the highest level of nursing education I have completed is (please check one):

Diploma       Associates       Baccalaureate       Masters       Doctorate

<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> _____ / _____ / _____ <span style="float: right;">MM/DD/YYYY</span>	

<b>Provide the name and location of your APRN Program</b>	Name	City, State
<b>Area of Concentration</b>		
<b>Circle One:</b> Degree      Certificate <b>Date Awarded:</b> _____ / _____ / _____ <span style="float: right;">MM/DD/YYYY</span>		

<b>Provide the name and location of your APRN Program</b>	Name	City, State
<b>Area of Concentration</b>		
<b>Circle One:</b> Degree      Certificate <b>Date Awarded:</b> _____ / _____ / _____ <span style="float: right;">MM/DD/YYYY</span>		

\*Attach additional pages if necessary

**Section E: APRN Education Program Requirements**

<b>Have you graduated from your original/initial APRN Nursing education program within the last five (5) years (04/01/2006 – 03/31/2011)?</b>	Yes	No
<b>Provide the date of completion of this APRN nursing program (MM/DD/YYYY).</b>	/	/

**Section F: APRN RE-ENTRY Program Requirements**

Have you successfully completed a Board approved APRN Re-entry program within the last five (5) years (04/01/2006 – 03/31/2011)?	Yes	No
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Provide the name and location of your APRN RE-ENTRY PROGRAM	Name		
	City	State	Country

Provide the date of completion of this re-entry program (MM/DD/YYYY).	/ /
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**Section G: Practice & Experience Requirements**

**Chapter 5. NURSING Subchapter 2 LICENSURE AND ENDORSEMENT IV. LICENSE RENEWAL**

Practice of nursing at the level of licensure within the past five years means practice as described in 26 V.S.A. § 1614, definitions, for at least 120 days, 960 hours, in the five years prior to the expiration date or 50 days, 400 hours, within the two years prior to the expiration date. Eight hours are equivalent to one day of nursing practice.

<p><b><u>Have you practiced as an APRN:</u></b>  <b>for 50 days (400 hours) within the last two (2) years</b>  <b>-OR-</b>  <b>for 120 days (960 hours) within the last five (5) years?</b></p>	Yes	No
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**Provide the following information for all APRN employment within the last five (5) years**

(Most recent employment first): Attach additional pages if necessary.

<b>Your Job Title</b>		
<b>Paid or Volunteer?</b>		
<b>Full time</b>	<b>Yes</b>	<b>No</b>
<b>Part time</b>	<b>Yes</b>	<b>No</b>
<b>Date of Employment</b>	<u>From (MM/DD/YYYY)</u> / /	<u>To (MM/DD/YYYY)</u> / /
<b>Name of Agency/Institution</b>		
<b>Mailing Address</b>	P.O. Box	
	Street/Apt #	
	City/State/Zip/Country	
<b>Agency/Institution Phone #</b>		
<b>Physician or Supervisor's Name and Title if applicable</b>		
<b>Physician or Supervisor's Phone Number if applicable</b>		

<b>Your Job Title</b>		
<b>Paid or Volunteer?</b>		
<b>Full time</b>	<b>Yes</b>	<b>No</b>
<b>Part time</b>	<b>Yes</b>	<b>No</b>
<b>Date of Employment</b>	<u>From (MM/DD/YYYY)</u> / /	<u>To (MM/DD/YYYY)</u> / /
<b>Name of Agency/Institution</b>		
<b>Mailing Address</b>	P.O. Box	
	Street/Apt #	
	City/State/Zip/Country	
<b>Agency/Institution Phone #</b>		
<b>Physician or Supervisor's Name and Title if applicable</b>		
<b>Physician or Supervisor's Phone Number if applicable</b>		

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<b>Your Job Title</b>		
<b>Paid or Volunteer?</b>		
<b>Full time</b>	<b>Yes</b>	<b>No</b>
<b>Part time</b>	<b>Yes</b>	<b>No</b>
<b>Date of Employment</b>	<b><u>From (MM/DD/YYYY)</u></b> / /	<b><u>To (MM/DD/YYYY)</u></b> / /
<b>Name of Agency/Institution</b>		
<b>Mailing Address</b>	P.O. Box	
	Street/Apt #	
	City/State/Zip/Country	
<b>Agency/Institution Phone #</b>		
<b>Physician or Supervisor's Name and Title if applicable</b>		
<b>Physician or Supervisor's Phone Number if applicable</b>		

<b>Your Job Title</b>		
<b>Paid or Volunteer?</b>		
<b>Full time</b>	<b>Yes</b>	<b>No</b>
<b>Part time</b>	<b>Yes</b>	<b>No</b>
<b>Date of Employment</b>	<b><u>From (MM/DD/YYYY)</u></b> / /	<b><u>To (MM/DD/YYYY)</u></b> / /
<b>Name of Agency/Institution</b>		
<b>Mailing Address</b>	P.O. Box	
	Street/Apt #	
	City/State/Zip/Country	
<b>Agency/Institution Phone #</b>		
<b>Physician or Supervisor's Name and Title if applicable</b>		
<b>Physician or Supervisor's Phone Number if applicable</b>		

Name: \_\_\_\_\_  
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**Section H: Private Duty or Volunteer**

Did you practice as an Advanced Practice Nurse (APRN) in a private duty or volunteer capacity?	Yes	No
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If **YES** to the question above attach the following documentation:

Private Duty:

1. An Official letter from the client/patient's Attending Physician on their letterhead, stating that APRN care was required. The letter must clearly list the Physician's 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. 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 Physician, 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 Physician, Director of Nursing or Director of Human Resources, their telephone number, email address, mailing address and have their signature

**Section I: Required Attachments**

<ul style="list-style-type: none"><li>• Submit a copy of your current national advanced nursing practice specialty certification</li><li>• Practice guidelines must be the original, signed and dated by you and collaborating provider - if you are in the transition to practice period.</li><li>• If you do <b>not</b> require a Collaborative provider, practice guidelines must still be the original, signed and dated by you.</li></ul> <p><b>Copies and non-current practice guidelines will not be accepted.</b></p> <p><b>Practice guidelines are required prior to employment.</b></p>
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**Section J: Affirmation**

**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 renewal or further disciplinary action. The maximum penalty for perjury is fifteen years in prison and/or a \$10,000 fine. (13 V.S.A. §2901)

<b>Signature of Applicant</b>	<b>Date</b>
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**Office of Professional Regulation Survey (optional)**

Would you be willing to serve as an Ad Hoc member of the Board/Commission/Advisory panel for your profession?  <i>If you answer "Yes," submit a letter of intent and resume to the Office for consideration.</i>	Yes	No
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Would you be willing to serve as a Board/Advisor member of the Board/Commission/Advisory panel for your profession?  <i>If you answer "Yes," submit a letter of intent and resume to the Office for consideration.</i>	Yes	No
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Would you be willing to serve as an Expert Witness for licensing cases associated with your profession?	Yes	No
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If you answered "Yes" to the question above, what is your area of expertise?