

Office of Professional Regulation  
 Vermont Board of Nursing  
**NCLEX-RN Retake Application – International Applicants**

2x2 Recent Photo- Paste Here	Application Fee: \$30.00
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.**

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

Agency- If applicable list Agency Name and Address			
Name: _____		Email address: _____	
_____			
(Street or PO Box)	(State)	(Country)	(Zip/Postal Code)

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

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)).

Number of times you have taken the NCLEX: _____				
<u>Dates Taken:</u> _____				
Month/Year	Month/Year	Month/Year	Month/Year	Month/Year

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.

**A Passport Number IS required if you do not have a Social Security Number.**

Passport #: _____	Country of Issue: _____	Expiration Date: _____
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Home Telephone:_(____)_____	Cell Phone:_(____)_____
Work Phone:_(____)_____	Email 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 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))

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## Section D: Enclosures

1. Graduates of International nursing schools must enclose:
  - A copy of their current passport or U.S. identification
  - A copy of their current RN license
  - The Practice Requirement (pages 4 and 5)

## Section E: Requirements

1. If you have not re-taken the examination within 2 years of the initial examination you must complete a formal NCLEX review course. Please submit the certificate of completion and the final overall scores to our office for review.
2. If you have failed the NLCEX **two (2)** times:  
You must complete an NCLEX review course and submit the Certificate of Completion and Final Overall Scores to our office for review.

If you have failed the NCLEX **three (3) or four (4)** times:

You must complete a different NCLEX review course and submit the Certificate of Completion and Final Overall Scores to our office for review. You must ALSO submit a letter describing to the Board of Nursing what you have done to ensure your success on the NCLEX in order to be considered for possible approval to test.

If you have failed the NCLEX **five (5)** times:

Contact the Board of Nursing Office for information.

When space is insufficient, attach additional sheets.

### 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.)

**Signature:**

**Date:**

Please send completed application and fee to:  
Board of Nursing  
Office of Professional Regulation  
National Life Building, North, Floor 2  
Montpelier, VT 05620-3402



**PLEASE PRINT CLEARLY**

_____	_____	_____	_____
<b>Last Name/Sur Name Name</b>	<b>First Name</b>	<b>MI</b>	<b>Former/Maiden</b>

**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)	

3. If you practiced as a registered nurse in a *private duty capacity* or as a *volunteer*, attach:

Private Duty:

1. An Official letter from the Attending Physician on their letter head, stating that RN care was required. The letter must clearly list the Physicians 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 Director of Nursing or Director of Human Resources. A copy of your Job Description as a Volunteer Nurse, 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.

**Statement of Applicant**

**I hereby certify that all information I have provided in this application is true and accurate to the best of my knowledge. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application for licensure or further disciplinary sanction.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Vermont Board of Nursing  
Verification of International Registered Nursing Licensure – Re-Take Enclosure

**APPLICANT:** Complete the applicant section of this form and forward it to the licensing authority in the country in which you obtained your license. Please print. **MOST LICENSING AUTHORITIES CHARGE A FEE TO COMPLETE THIS FORM.**

Name \_\_\_\_\_  
(Last) (First) (Middle) (Former)

Address \_\_\_\_\_  
(Street) (City) (State) (Country) (Post Code)

Date of Birth: \_\_\_\_\_ License# \_\_\_\_\_ Date Issued \_\_\_\_\_

**I hereby authorize the Licensing Authority in the Country of \_\_\_\_\_ to furnish to the Vermont Board of Nursing the information requested below.**

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
=====

**COUNTRY LICENSING AUTHORITY:** Please complete the bottom of this form and return to: Vermont Board of Nursing, National Life Bldg., North, FL2, Montpelier, VT 05620-3402.

License Number \_\_\_\_\_ Country \_\_\_\_\_ Date Issued \_\_\_\_\_ Date Expired \_\_\_\_\_

If licensed/certified by endorsement please indicate state or country endorsed from: \_\_\_\_\_

Licensed By: ( ) Examination ( ) Endorsement/Reciprocity ( ) Waiver (If Yes, Please Explain) ( ) Other

License Status: ( ) Active ( ) Inactive ( ) Lapsed ( ) Other

Has this license ever been encumbered in any way (revoked, suspended, limited, surrendered, restricted, placed on probation, etc.)? ( ) Yes ( ) No If yes, attach a copy of the decision.

List name of exam taken: \_\_\_\_\_

Number of times applicant wrote the examination? \_\_\_\_\_

Name of Nursing Education Program Completed \_\_\_\_\_

Location (City and State) \_\_\_\_\_ Year Graduated \_\_\_\_\_

Was the nursing program accredited or government approved? \_\_\_\_\_ YES \_\_\_\_\_ NO

By what accrediting body or government agency? \_\_\_\_\_

(OFFICIAL SEAL)

\_\_\_\_\_  
Name of Licensing Agency

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Title Date

Please send 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)