

Office of Professional Regulation
 Vermont Board of Nursing
Licensed Practical Nurse Re-Entry Application for Temporary Permit

Application Fee: \$25	For Office Use Only:
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Directions:

This application must accompany your Endorsement or Renewal Application.

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

The purpose of re-entry programs is to prepare licensed practical nurses who do not meet practice requirements for renewal or endorsement to be eligible for licensure. Re-entry programs must be pre-approved by the Board of Nursing.

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

Section A:

Name: _____			
(Last)	(First)	(Middle)	(Former/Maiden)
Mailing address: _____			
(Street or 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: Re-Entry Program

Name of Re-Entry Program: _____

Name of Parent Organization if different: _____

Physical Location: _____

Mailing Address: _____

Name of Program Director: _____

Name of Vermont Program Coordinator/Faculty: _____ Vermont License #: _____

The Re-Entry program consists of _____ hours of Theory and _____ hours of Clinical Practice.

Location of Clinical Practice Portion of Re-Entry Program: _____

Name and Title of Clinical Preceptor: _____

Vermont Nursing License number of Clinical Preceptor: _____

The clinical portion of the Re-Entry program will begin on:

_____/_____/_____ and will be completed on ____/____/_____
MM DD YYYY MM DD YYYY

Signed by Vermont Program Coordinator: _____ Date: _____

Signed by Clinical Preceptor: _____ Date: _____

Section C: Enclosures

- Completed Vermont LPN Renewal form or Endorsement application.

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. 3 VSA §2901.)

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

Re-Entry Evaluation of LPN Applicant

Instructions: This needs to be submitted and signed by the Program Director or Vermont Program Coordinator to verify successful completion of both the theory and clinical practice portions of the Re-Entry program.

Applicant Name _____

Demonstrates an adequate theoretical knowledge base as defined in the program outline?	Yes No
Assesses patient accurately? Skills requiring more practice: _____	Yes No
Assesses patients accurately? Areas needing more attention: _____	Yes No
Communicates effectively through verbal and written modes? Areas needing more practice: _____	Yes No
Develops a nursing care plan appropriate to the individual's needs utilizing nursing diagnoses?	Yes No
Evaluates the effectiveness of nursing interventions? Areas needing more practice: _____	Yes No
Demonstrates critical thinking skills?	Yes No
Do you recommend this applicant for licensure?	Yes No
Successfully completed 80 hours of Theory?	Yes No
Successfully completed 80 hours of Clinical Practice?	Yes No

Enclosure:

Re-Entry Program for Licensed Practical Nurses Clinical Skills Checklist.

<p>I certify, under the pains and penalties of perjury, that all information I have provided is true and accurate. I understand that furnishing false information can constitute unprofessional conduct. (The maximum penalty for perjury is fifteen years in prison and/or a \$10,000 fine. 3 VSA §2901.)</p>	
Signed by Vermont Program Coordinator: _____	Date: _____
Signed by Clinical Preceptor: _____	Date: _____

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**Re-Entry Program for Licensed Practical Nurses
Clinical Skills Checklist**

Name of Applicant: _____ Date: _____

Directions:

Assess the ability of the nurse for each skill listed below and date the appropriate column. Skills identified with an asterisk must be performed in a clinical setting. The clinical preceptor may delegate to others the teaching and observation of the skills listed below. However, the clinical preceptor retains accountability for assuring the applicant's competence. Individuals initialing this document must print and sign their full name and title at the end of this document.

	Skill Performed in Lab (date)	Skill Performed in Clinical Setting (date)	Preceptor Initials	Comment
Basic Cardiac Life Support *				
Heimlich maneuver *				
LIFTING AND MOVING				
Patient Positioning				
Transfer Techniques				
Mechanical				
Non-mechanical				
ASEPSIS				
Hand Washing				
Standard Precautions				
Isolation				
ELIMINATION				
Catherization				
Specimen Collection				
Enema				
Stoma Care				
Intake and Output				
VITAL SIGNS				
Respiration				
Pulse				
Apical				
Radial				
Femoral				
Pedal				

Temperature				
Blood Pressure				
MEDICATION ADMINISTRATION*				
Oral				
Blood Glucose				
Parenteral				
IV INFUSION				
Regulate *				
Dressing Change *				
Discontinuation *				
Infusion Pump				
NUTRITION				
Nasogastric Tubes				
Irrigation				
Feeding Pump Usage				
Suction				
OXYGEN THERAPY				
Pulse Oximeter				
Nasal/Mask				
Incentive Spirometer				
WOUND CARE				
Sterile Dressing				
Non-sterile Dressing				
SUCTIONING				
Oral				
Naso Pharyngeal				
Tracheal				
COMMUNICATION				
Documentation				
Oral / Written				

**Re-Entry Program for Licensed Practical Nurses
Clinical Skills Checklist**

Signature Page:

Initials: _____ Signed by: _____ Printed Name: _____ Title: _____

Initials: _____ Signed by: _____ Printed Name: _____ Title: _____

Initials: _____ Signed by: _____ Printed Name: _____ Title: _____

Initials: _____ Signed by: _____ Printed Name: _____ Title: _____

Initials: _____ Signed by: _____ Printed Name: _____ Title: _____

Initials: _____ Signed by: _____ Printed Name: _____ Title: _____

Approved 7-28-09