

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

2x2 Recent Photo- Paste Here  Passport sized photo of head and shoulders taken within the last 6 months <b>other than</b> your driver's license or passport.	Application Fee: \$150.00
	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.**

**All required documents for this application must be received by this office within 1 year of receipt. If application remains incomplete after 1 year, it will be destroyed. If you are interested in reapplying, a new application and fee must be submitted.**

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

**Section A:**

Name: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>(Last)</span> <span>(First)</span> <span>(Middle)</span> <span>(Former/Maiden)</span> </div>
Mailing address: _____ <div style="text-align: center;">(Street or P.O. Box)</div>
_____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>(City)</span> <span>(State)</span> <span>(Zip Code)</span> </div>

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: _____

Have you ever held a Vermont license before?  No  Yes  
 If yes, when? \_\_\_\_\_ What type of license? \_\_\_\_\_

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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))

\*\* 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: EDUCATION**

Complete the information below regarding the program that lead to your initial RN licensure:

Name of Nursing School/College/University \_\_\_\_\_

City, State \_\_\_\_\_ Date of Graduation \_\_\_\_\_ Degree Earned \_\_\_\_\_  
MM/DD/YYYY

As of the date of this application, the highest level of nursing education I have completed is:

- Diploma                       Baccalaureate                       Doctorate
- Associate Degree                       Masters

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**Section E: LICENSE INFORMATION**

State of original licensure: _____		Original license number _____	
Date issued: _____		Exam Name: _____	
All other states in which you hold or have held a nursing license: (Please attach additional sheets if necessary)			
State	Date Licensed	Expiration/Inactive Date	License Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Section F: PRACTICE REQUIREMENTS**

1. I graduated from my entry level RN education program within the last five years. Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes" date of graduation \_\_\_\_\_ Name of Nursing Program \_\_\_\_\_  
(MM/DD/YYYY)

Please note that if you do *not* meet the work history requirement *and* have graduated *within the last five years* you must also file the *Verification of Education - RN (Domestic)* form. This form must be completed by your school of nursing, and sent directly to our office along with an official copy of your transcripts. (You may also bring these documents from the school in a sealed envelope) You will not be issued a temporary license until this form has been received and reviewed by the Nursing Board.

If "No" complete the questions below.

2. I have practiced as a registered nurse as defined in (26 V.S.A. §1576(c); Rules Ch. 4, Subch. 2, Rules (III)(A), (VI)(A) and (B)) , for at least 50 days (400 hours) within the last 2 years or 120 days (960 hours) within the last five years: Yes \_\_\_\_\_ No \_\_\_\_\_

3. Provide the following information for all RN employment within the last 5 years (paid, volunteer, or private duty work); attach additional sheets if necessary:

**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 a 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 RN 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. 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.

5. I have successfully completed a Board approved RN Re-entry/Refresher program (26 V.S.A. §1576(c); Rules Ch. 4, Subch. 2, Rules (III)(A), (VI)(A) and (B)). Yes \_\_\_\_\_ No \_\_\_\_\_

If you have completed a re-entry program 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 RN Re-entry/Refresher program: \_\_\_\_\_

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

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**Section G: Temporary License**

I am requesting a temporary license to practice as a RN. \_\_\_\_\_ Yes \_\_\_\_\_ No

THE 90 DAY TEMPORARY LICENSE CAN NOT BE EXTENDED.

**Section H:** Required Enclosures – The following **must** be submitted for licensure.

- A photocopy of your current out-of-state nursing license (showing expiration date)
- A photocopy of your current driver’s license, government issued ID or passport.

**Section I: Verification of Licensure**

Provide verification of your original nursing license as well as the nursing license from your most recent state of nursing employment. If those states are members of NURSYS, please go to their website ([www.nursys.com](http://www.nursys.com)) to obtain license verifications. If they are not members of NURSYS, please use the attached forms.

**Statement of Applicant**

<p>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.)</p>	
<hr style="border: 0.5px solid black;"/> <p>Signature of Applicant</p>	<hr style="border: 0.5px solid black;"/> <p>Date:</p>

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)

End of Application

Office of Professional Regulation  
Vermont Board of Nursing

**Verification of Licensure – State of Original Nursing Licensure**

**APPLICANT:** Complete the applicant section of this form and forward it to the Board of Nursing in which you obtained your original license. Please print. **MOST BOARDS OF NURSING 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 \_\_\_\_\_ 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 \_\_\_\_\_ 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 approved? \_\_\_\_\_ YES \_\_\_\_\_ NO

By what accrediting body(s)? \_\_\_\_\_

(OFFICIAL SEAL)

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

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Office of Professional Regulation  
Vermont Board of Nursing

**Verification of Licensure –State of Most Recent Nursing Employment**

**APPLICANT:** Complete the applicant section of this form and forward it to the Board of Nursing in the state of your most recent nursing employment. Please print. **MOST BOARDS OF NURSING 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 \_\_\_\_\_ 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 \_\_\_\_\_ 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 approved? \_\_\_\_\_ YES \_\_\_\_\_ NO

By what accrediting body(s)? \_\_\_\_\_

(OFFICIAL SEAL)

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

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date