

Office of Professional Regulation  
 Vermont Board of Nursing  
**Registered 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 registered 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:  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: 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 RN 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 RN 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 120 hours of Theory?	Yes	No
Successfully completed 120 hours of Clinical Practice?	Yes	No

**Enclosure:**

Re-Entry Program for Registered Nurses Clinical Skills Checklist.

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. 13 VSA §2901.)	
Signed by Vermont Program Coordinator: _____	Date: _____
Signed by Clinical Preceptor: _____	Date: _____

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**Re-Entry Program for Registered 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
<b>ASSESSMENT* All of the following:</b>				
<b>HEALTH HISTORY</b>				
<b>INTEGUMENT</b>				
Color				
Turgor				
Lesion description				
<b>RESPIRATORY</b>				
Auscultation lung sounds				
Pattern/Measurement				
Cardiac				
Apical/ Radial Pulse				
Blood Pressure				
Telemetry Monitoring				
<b>PERIPHERAL VASCULAR</b>				
Edema Assessment				
Peripheral Pulses				
<b>ABDOMINAL</b>				
Bowel Sounds				
<b>MUSCULOSKELETAL</b>				
Symmetry				
Strength/Movement				
<b>NEUROLOGICAL</b>				
Level of Consciousness/Orientation				
Sensory				
Pupil checks				
Reflexes				

<b>PLANNING* All of the Following:</b>				
Formulate Nursing diagnosis				
Develop a Plan of Care				
<b>IMPLEMENTATION</b>				
Asepsis				
Hand washing				
Standard Precautions*				
Isolation				
Basic Cardiac Life Support*				
Heimlich maneuver*				
Lifting and Moving				
Patient Positioning				
Transfer Techniques				
Mechanical				
Non-mechanical				
Range of Motion				
<b>ELIMINATION</b>				
Catherization – insertion/removal/irrigation				
Urine Specimen				
Enema				
Stoma/Ostomy Care				
<b>MEDICATION ADMINISTRATION* All of the following:</b>				
Dosage Calculation				
Oral, Parenteral				
IV Push				
Narcotic Counts				
Pain Assessment				
Blood Glucose				
<b>IV INFUSION</b>				
Set-up/hang/regulate*				
Dressing Changes*				
Saline lock maintenance*				
Discontinuation*				
Infusion pump*				

Central Line Maintenance				
Blood administration				
Total parenteral nutrition				
<b>NUTRITION</b>				
Nasogastric Insertion/irrigation				
Tube feeding				
Suction				
Intake & Output				
<b>OXYGEN THERAPY*</b>				
Nasal/mask				
Incentive Spirometer				
<b>SUCTIONING</b>				
Oral				
Nasopharyngeal				
Tracheal				
Tracheostomy care				
<b>WOUND CARE</b>				
Sterile Dressing				
Non-sterile Dressing				
<b>COMMUNICATION</b>				
Documentation/written/oral*				
Patient Teaching*				
<b>EVALUATION* - All of the following</b>				
Effectiveness of plan of care				
Revision of plan of care				

**Re-Entry Program for Registered 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