

Nevada State Board of NURSING

Application for Renewal

Return to: Nevada State Board of Nursing, 5011 Meadowood Mall Way, Suite 300, Reno, NV 89502-6576
Toll free (888) 590-6726 | fax (775) 687-7707 or (702) 486-5803 | nursingboard@nsbn.state.nv.us
www.nevadanursingboard.org

This renewal application with the appropriate fee (see fee table on reverse) must be received on or before the end of the business day on which your current license expires. **Nevada has no grace period**—if your application is received after your license expires, you must include a late fee of \$100. Fees are not refundable (NRS 632.345).

To practice nursing in Nevada, you must hold an active Nevada license.

No license card will be mailed. You may verify your current licensure status on our website.

License Type: RN LPN APRN **Certificate Type:** CRNA EMS

First Name

Last Name

Social Security #

Date of Birth

Telephone

Mailing Address (This address will become your permanent address of record.)

Apt.

City

State

ZIP

License #

Email Address

I wish to place my license on inactive status (NO FEE REQUIRED): Yes No

If you marked "Yes," you need not complete the rest of the form. If you marked "No," please complete the entire form.

It is a violation of Nevada law to falsify this application, and sanctions may be imposed for fraud or misrepresentation.
Incomplete applications will cause a delay and may cause your license to lapse.

Section 1. General

Yes <input type="radio"/>	No <input type="radio"/>	I am subject to a court order that requires me to pay for the support of one or more children.
Yes <input type="radio"/>	No <input type="radio"/>	N/A <input type="radio"/>
I am in compliance with that court order. (If you answered <i>No</i> to the question above, mark N/A.)		
Yes <input type="radio"/>	No <input type="radio"/>	I have a Nevada state business license.

Section 2. Practice and Education

I last practiced nursing on this date?		MM/DD/YY	In what state?	(You must indicate a date. Phrases such as TODAY, CURRENTLY, PRESENTLY, STILL PRACTICING, etc. will cause a delay in processing your application.)
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) I have completed 30 hours of continuing education within the previous two years. (Retain certificates for years in case of audit.)		
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) I have completed the one-time 4 hour bioterrorism CE. (Retain certificate indefinitely in case of audit.)		
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) that I have knowledge of and am in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.		
Yes <input type="radio"/>	No <input type="radio"/>	Pursuant to state law, I am aware that I am a mandatory reporter of child abuse.		

Section 3. Eligibility Screening Questions

(If you answer "Yes" to any of Questions 1 through 6 below, you must attach a written explanation.)

Yes <input type="radio"/>	No <input type="radio"/>	<p>1. Since your previous Nevada license/certificate was issued, has your application, or your license, registration, certificate, or privilege to practice in any jurisdiction, of any level (does not include driver's license or car registration):</p> <ol style="list-style-type: none">Been denied or disciplined by a regulatory Board including but not limited to reprimanded, censured, fined, suspended, revoked, surrendered, limited or restricted, or placed on probation or monitoring?Been subject to a non-disciplinary probation or monitoring program? AND/ORIs your license the subject of a current investigation, inquiry, pending settlement or hearing in any state or jurisdiction? <p><i>If any answer is Yes, you must submit the following:</i></p> <ol style="list-style-type: none"><i>A detailed letter of explanation that includes the state or jurisdiction where the action occurred or is pending; and</i><i>Copies of documents from the state or jurisdiction where there has been action, current investigation, or inquiry.</i>
Yes <input type="radio"/>	No <input type="radio"/>	<p>2. Since your previous Nevada license/certificate was issued, have you had a criminal conviction, including a misdemeanor or felony, or had a civil judgment rendered against you?</p> <p><i>If the answer is Yes, you must submit the following:</i></p> <ol style="list-style-type: none"><i>A detailed letter of explanation including the events leading to your conviction; and</i><i>Copies of court documents, including the actual conviction, sentence, and current status of sentence (i.e. all fines paid in full, completion letter from Parole or Probation Officer, etc.).</i>
Yes <input type="radio"/>	No <input type="radio"/>	<p>3. Do you currently use chemical substances in any way which impairs or limits your ability to practice the full scope of nursing?</p> <p><i>If the answer is Yes, you must submit:</i></p> <ol style="list-style-type: none"><i>A letter of explanation that addresses the impairment or limitations of practice; and</i><i>If you are using the chemical substance as a confirmed medical necessity, a letter from your treating practitioner documenting the diagnosis and medical necessity for the use of chemical substances, including any practice limitations.</i>
Yes <input type="radio"/>	No <input type="radio"/>	<p>4. Are you currently in recovery for chemical dependency, chemical abuse or addiction?</p> <p><i>If the answer is Yes, you must submit:</i></p> <ol style="list-style-type: none"><i>A letter of explanation describing your recovery experience, including length of continuous recovery, treatment, current recovery activities, and relapse prevention plan;</i><i>Documentation from knowledgeable individual(s) documenting your length of sobriety; and</i><i>Documentation of a substance use evaluation, and inpatient or outpatient chemical dependency treatment (if applicable).</i>
Yes <input type="radio"/>	No <input type="radio"/>	<p>5. Do you currently have a medical or psychiatric/mental health condition which in any way impairs or limits your ability to practice the full scope of nursing?</p> <p><i>If the answer is Yes, you must submit:</i></p> <ol style="list-style-type: none"><i>A letter of explanation regarding your condition, whether temporary or permanent, including diagnosis, past hospitalizations, date of last treatment, current treatment plan, and how your condition may interfere with your ability to practice the full scope of nursing safely; and</i><i>Documentation from treating practitioner regarding the diagnosis, (Axis I-V for psychiatric diagnosis), medications, current status and treatment plan, the extent of condition, and statement regarding your ability to carry out nursing duties reliably and with good judgment.</i>
Yes <input type="radio"/>	No <input type="radio"/>	<p>6. Since your previous Nevada license/certificate was issued have you had a malpractice judgment or settlement entered against you, or do you have any pending malpractice suits or claims filed against you?</p> <p><i>If the answer is Yes, you must submit:</i></p> <ol style="list-style-type: none"><i>A detailed letter of explanation regarding the events leading to the suit; and</i><i>A copy of the complaint and current status of the case.</i>

Section 4. For APRN Renewal Only

Yes <input type="radio"/>	No <input type="radio"/>	I wish to place my APRN license on inactive status. NO FEE REQUIRED. <i>If yes, do not complete the rest of this section. If no, please complete the rest of this section.</i>
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) that during the previous five years, I have worked 1,000 hours in my area of specialization.
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) that within the previous two years, I have completed 15 contact hours of continuing education related to my specialty. <i>(Retain certificates for four years in case of audit.)</i>
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) that within the previous four years, I have completed 2 contact hours of continuing education on evidence-based suicide prevention and awareness. <i>(These hours may be included in the 15 contact hours related to your specialty)</i>
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) that within the previous two years, I have completed 2 hours of training related specifically to the misuse and abuse of controlled substances. <i>(These hours may be included in the 15 contact hours related to your specialty)</i>

My current practice site is, Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

My collaborating physician, if applicable, is (Name): _____ (License #) _____

Collaborator's specialty _____ Date collaboration commenced _____

Section 5. For CRNA Renewal Only

Yes <input type="radio"/>	No <input type="radio"/>	I wish to place my CRNA certificate on inactive status NO FEE REQUIRED. <i>If you marked yes, do not complete the rest of this section. If you marked no, please complete the rest of this section.</i>
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) that within the previous two years, I have completed 45 contact hours of continuing education related to practice as a nurse anesthetist. <i>(Retain certificates for four years in case of audit.)</i>
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) am currently nationally certified as a nurse anesthetist from AANA or NBCRNA. <i>If yes, you must submit a copy of your current national certification to the Board of Nursing within 30 days of the date of this application.</i>

Section 6. For EMS/RN Renewal Only

Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) I am currently certified in advanced life support procedures for adult patients.
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) I am currently certified in advanced life support procedures for pediatric patients.
Yes <input type="radio"/>	No <input type="radio"/>	I affirm (swear) I am currently certified in advanced life support procedures for patients with trauma that are administered before arrival of those patients at a hospital in a program that is approved by the Board.

Section 7. Military Status

Yes <input type="radio"/>	No <input type="radio"/>	I am an active United States military member or a United States military veteran
Yes <input type="radio"/>	No <input type="radio"/>	I am the spouse of an active United States military member or surviving spouse of a veteran.
Yes <input type="radio"/>	No <input type="radio"/>	Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable?"

Yes <input type="radio"/>	No <input type="radio"/>	Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable?"
Yes <input type="radio"/>	No <input type="radio"/>	Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable?"

Affirmation. All Applicants Must Complete

I affirm (swear) that I have read this application and the statements made are true and correct. *If I have indicated a credit card number below, I authorize the application fee be charged to that credit card.*

Signature _____ Date: _____

Fingerprinting is required every third renewal. If you are required to fingerprint you will be issued a 6 month renewal to allow you to complete the fingerprinting process. Due to various factors, it may take up to four months for the Board to receive the official fingerprint results from the Department of Public Safety and FBI; therefore, you are encouraged to fingerprint immediately.

Fees		You may pay by credit/debit card (Visa, MasterCard, Discover, American Express), personal or cashier's check, or money order, made payable to the Nevada State Board of Nursing or NSBN . Remit US funds only.
RN	\$100.00	
LPN	\$100.00	
Late Fee	\$100.00	
APRN	\$200.00	
CRNA	\$200.00	
RN+APRN	\$300.00	
RN+CRNA	\$300.00	

If paying by credit card, please complete

Visa MasterCard Discover American Express

Card Number _____ Expiration Date _____

Name on card _____ Amount \$ _____