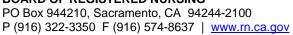


## **BOARD OF REGISTERED NURSING**





## ONLINE CLINICAL NURSE SPECIALIST APPLICANT IDENTIFICATION FORM

You <u>must</u> complete and submit this form with the required supporting documents to: Board of Registered Nursing, ATTN: Advanced Practice Unit, P.O. Box 944210, Sacramento, CA 94244-2100.

APPLICATION NUMBER: 4003				
Print Full Name:				
(Last) U.S. Social Security Number or	(First)		(Middle	)
Individual Taxpayer Identification				
Number:	E-Mail: _			
Address:		Date of Birth		
Name of Clinical Nurse Program:				
City, State and Country of Clinical Nurse Specialist Program:				
INDICATE ALL FEES PAID ONLINE BY CREDIT CARD:				
☐ Application fee - \$150.00				
HAVE YOU COMPLETED AND/OR ENCLOSED THE FOLLOWING ITEMS (check all that apply):				
Have you attached a recent 2" x 2" passport type photograph?			☐ YES	□NO
If applicable, is supplemental information regarding reporting prior convictions or discipline YES NO against licenses enclosed?				
I certify under penalty of perjury under the laws of the State of Ca that all information provided in connection with this online applica licensure is true, correct and complete. Providing false informatio omitting required information is grounds for denial of licensure or revocation in California.  Signature of Applicant:  Date:	tion for on or	Pas	Tape Your 2" x 2" Passport Type Photograph Here	