In this change without a regulatory effect, the Board amends its regulation to update the revision date of three application forms incorporated by reference, which are changed to reflect the new Governor, Gavin Newsom, on the letterhead of the forms.

OAL approves this change without regulatory effect as meeting the requirements of California Code of Regulations, title 1, section 100.

Date: April 24, 2019

Thanh Huynh
Senior Attorney

For: Holly Pearson
Acting Director

Original: Joseph Morris, Executive Officer
Copy: Dean Fairbanks
A. PUBLICATION OF NOTICE  (Complete for publication in Notice Register)

<table>
<thead>
<tr>
<th>SUBJECT OF NOTICE</th>
<th>TITLE(S)</th>
<th>FIRST SECTION AFFECTED</th>
<th>REQUESTED PUBLICATION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. NOTICE TYPE  

<table>
<thead>
<tr>
<th>Regulatory Action</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice re Proposed</td>
<td></td>
</tr>
</tbody>
</table>

4. AGENCY CONTACT PERSON  

<table>
<thead>
<tr>
<th>TELEPHONE NUMBER</th>
<th>FAX NUMBER (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. SUBMISSION OF REGULATIONS  (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)  

Advance Practice Registered Nurses (APRN) Applications

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

<table>
<thead>
<tr>
<th>SECTION(S) AFFECTED</th>
<th>ADOPT</th>
<th>AMEND</th>
<th>REPEAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1483</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. TYPE OF FILING  

<table>
<thead>
<tr>
<th>Regular Rulemaking (Gov. Code §11346)</th>
<th>Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §511346)</th>
<th>Emergency (Gov. Code §11346)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §511346,3-11347,3 before the emergency regulation was adopted or within the time period required by statute.</td>
<td>Resubmittal of disapproved or withdrawn emergency filing (Gov. Code §511346,1f)</td>
<td>Emergency Readopt (Gov. Code §511346,1f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency Readopt (Gov. Code, §11346,1f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>File &amp; Print</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other (Specify)</td>
</tr>
</tbody>
</table>

4. EFFECTIVE DATE OF CHANGES

<table>
<thead>
<tr>
<th>(Gov. Code §§11346.1, 11346.1d; Cal. Code Regs., title 1, §100)</th>
<th>(Gov. Code §§11346.1, 11346.1d; Cal. Code Regs., title 1, §100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective January 1, April 1, July 1, or October 1 (Gov. Code §11346,4f)</td>
<td>Effective on filing with Secretary of State</td>
</tr>
<tr>
<td>4100 Changes Without Regulatory Effect</td>
<td>Effective other (Specify)</td>
</tr>
</tbody>
</table>

5. EFFECTIVE DATE OF CHANGES  

<table>
<thead>
<tr>
<th>4100 Changes Without Regulatory Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective on filing with Secretary of State</td>
</tr>
</tbody>
</table>

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

<table>
<thead>
<tr>
<th>Department of Finance (Form STD. 399) (SAM §6660)</th>
<th>Fair Political Practices Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State Fire Marshal</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>State Fire Marshal</td>
</tr>
</tbody>
</table>

7. CONTACT PERSON:  

<table>
<thead>
<tr>
<th>DEAN FAIRBANKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(916) 574-7684</td>
</tr>
</tbody>
</table>

8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

<table>
<thead>
<tr>
<th>SIGNATURE OF AGENCY HEAD OR DESIGNEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOSPEH MORRIS, EXECUTIVE OFFICER, BOARD OF REGISTERED NURSING</td>
</tr>
</tbody>
</table>

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

APR 24 2019

Office of Administrative Law
Proposed changes are designated by single underline and strikeout.

(a) An application for evaluation of a registered nurse’s qualifications to be certified as a nurse practitioner shall be filed with the board by submitting the Application for Nurse Practitioner (NP) Certification (Rev. 03/20182019), which is hereby incorporated by reference. A temporary Nurse Practitioner (NP) certificate shall be obtained by submitting the Application for Temporary Nurse Practitioner (NP) Certificate (Rev. 03/20182019), which is hereby incorporated by reference. In order to furnish drugs or devices in California as a Nurse Practitioner, the certified nurse practitioner must be issued a Nurse Practitioner Furnishing Number by submitting the Nurse Practitioner Furnishing Number Application (Rev. 03/20182019), which is hereby incorporated by reference, for approval. Submission of each application shall be accompanied by the fee prescribed in Section 1417 and such evidence, statements or documents as therein required by the board.

(b) The Application for Nurse Practitioner (NP) Certification, the Application for Temporary Nurse Practitioner (NP) Certificate and the Nurse Practitioner Furnishing Number Application shall include submission of the name of the graduate nurse practitioner education program or post-graduate nurse practitioner education program.

(c) The Application for Nurse Practitioner (NP) Certification shall include submission of an official sealed transcript with the date of graduation or post-graduate program completion, nurse practitioner category, credential conferred, and the specific courses taken to provide sufficient evidence the applicant has completed the required course work including the required number of supervised direct patient care clinical practice hours.

(d) A graduate from a board-approved nurse practitioner education program shall be considered a graduate of a nationally accredited program if the program held national nursing accreditation at the time the graduate completed the program. The program graduate is eligible to apply for nurse practitioner certification with the board regardless of the program’s national nursing accreditation status at the time of submission of the application to the Board.

(e) The board shall notify the applicant in writing that the application is complete and accepted for filing or that the application is deficient and what specific information is required within 30 days from the receipt of an application. A decision on the evaluation of credentials shall be reached within 60 days from the filing of a completed application. The median, minimum, and maximum times for processing an application, from the receipt of the initial application to the final decision, shall be 42 days, 14 days, and one year, respectively, taking into account Section 1410.4(e) which provides for abandonment of incomplete applications after one year.

APPLICATION FOR NURSE PRACTITIONER (NP) CERTIFICATION

APPLICATION FEE - $500.00

PERSONAL DATA (PRINT OR TYPE)

LAST NAME: 
FIRST NAME: 
MIDDLE NAME: 

ADDRESS: Number and Street
City State Country Postal/Zip Code

HOME TELEPHONE NUMBER: 
ALTERNATE TELEPHONE NUMBER: 
EMAIL ADDRESS: 

DATE OF BIRTH: (Month/Day/Year)
U.S. SOCIAL SECURITY NUMBER/ PREVIOUS NAMES: (Including Maiden)
MOTHER'S MAIDEN NAME: (Last Only)

RN LICENSURE/NURSE PRACTITIONER CERTIFICATION

California RN License Number: 
Date issued: Expiration Date: 

List ALL States Where You Hold/Held an RN License and Status:

NURSE PRACTITIONER EDUCATION

Name of Professional Registered Nursing Program:
City State Country

TYPE OF PROGRAM:

ASSOCIATE DEGREE
DIPLOMA
BACCALAUREATE DEGREE
MASTERS DEGREE/NURSING

Entrance Date: 
Graduation/Completion Date:

NURSE PRACTITIONER EDUCATION

Name of Nurse Practitioner Academic Program:
City State Country

TYPE OF NURSE PRACTITIONER ACADEMIC PROGRAM:

CERTIFICATE
MASTERS
POST-MASTERS

Entrance Date: 
Graduation/Completion Date:

(Rev. 03/16)

(Questions on both sides of page)
NAME OF APPLICANT:

NURSE PRACTITIONER PROFESSIONAL CERTIFICATION (if Applicable):

<table>
<thead>
<tr>
<th>Name of Organization/Association</th>
<th>METHOD OF CERTIFICATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ EXAMINATION</td>
</tr>
<tr>
<td></td>
<td>□ OTHER (Please Explain):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area of Specialization:</th>
<th>Original Date of Certification:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

BACKGROUND INFORMATION

Have you applied for a Nurse Practitioner certificate in California? If yes, name on previous application:

<table>
<thead>
<tr>
<th>Date Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Have you ever been issued a Nurse Practitioner certificate in California?

If yes: STOP! DO NOT CONTINUE. Please contact the Board regarding whether you should register for the California Secretary of State Department of Consumer Affairs, Department of Business Oversight, for reinstatement of your California Nurse Practitioner certification.

Have you ever had disciplinary proceedings taken against any license, certificates, or any health-related license or certificate including revocation, suspension, suspension, revocation, suspension, suspension, suspension, suspension, or any other proceeding in any state or country? If yes, please provide a detailed written explanation, including the date and state or country where the discipline occurred.

<table>
<thead>
<tr>
<th>□ YES</th>
<th>□ NO</th>
</tr>
</thead>
</table>

Have you ever been convicted of any offense other than minor traffic violations? If yes, explain fully as described in the applicant instructions. Disclosures must be made even if they have been expunged or expunged or if a diversion program has been completed. Traffic offenses involving driving under the influence, injury to persons or providing false information must be reported. The definition of conviction includes a plea of nolo contendere (no contest), as well as pleas of guilty. YOU MUST INCLUDE MISDEMEANOR AS WELL AS FELONY CONVICTIONS.

<table>
<thead>
<tr>
<th>□ YES</th>
<th>□ NO</th>
</tr>
</thead>
</table>

I understand that I am required to report immediately to the California Board of Registered Nursing if I am convicted of ANY offense that occurs prior to the date of this application and the date that a California registered nurse license is issued. I am also required to report to the California Board of Registered Nursing any disciplinary action and/or voluntary surrender against ANY health-care related license/certificate that occurs between the date of application and the date that a California registered nurse license is issued. I understand that failure to provide the result in denial or revocation. Application or subsequent disciplinary action against my license/certificate.

I certify, under penalty of perjury under the laws of the State of California, that all information provided as a connection for this application for licensure is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure or license revocation in California.

SIGNATURE OF APPLICANT

DATE

"U.S. SOCIAL SECURITY NUMBER/TIN DISCLOSURE STATEMENT"

Disclosure of your U.S. Social Security Number/TIN is mandatory. Section 30 of the Business and Professions Code and Public Law 94-465 (42 USC section 408(c)(2)(C)) authorizes collection of your U.S. Social Security Number/TIN. Your U.S. Social Security Number/TIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with section 7600 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and whose license is reciprocal with the requesting state. If you fail to disclose your U.S. Social Security Number/TIN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may impose a $100 penalty against you.

Attach a recent 2"x2" passport type photograph.

Please tape on all four sides.

Head and shoulders only
### A. TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
<td></td>
<td>DATE OF BIRTH: (Month/Day/Year)</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Country</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>Previous Names (including Maiden)</td>
<td>Mother/Maiden Name (Last Name Only)</td>
</tr>
<tr>
<td>Home ( )</td>
<td>Alternate ( )</td>
<td></td>
</tr>
<tr>
<td>E-mail Address:</td>
<td>California RN License Number:</td>
<td>Expiration Date:</td>
</tr>
<tr>
<td>Name of Academic Program:</td>
<td></td>
<td>Specialty:</td>
</tr>
<tr>
<td>Signature of Applicant:</td>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

### B. TO BE COMPLETED BY THE PROGRAM DIRECTOR/REPRESENTATIVE FOR THE NURSE PRACTITIONER ACADEMIC PROGRAM

The above application is applied for nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at above address.

<table>
<thead>
<tr>
<th>Name of Nurse Practitioner Academic Program:</th>
<th>Telephone Number: ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: Number &amp; Street</td>
<td>City</td>
</tr>
<tr>
<td>State</td>
<td>Postal/Zip Code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Program:</th>
<th>Entrance Date: (Month/Day/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate</td>
<td>Completion Date: (Month/Day/Year)</td>
</tr>
<tr>
<td>Masters</td>
<td>Date Certificate/Degree Status Confirmed: (Month/Day/Year)</td>
</tr>
<tr>
<td>Post-Masters</td>
<td></td>
</tr>
</tbody>
</table>

**Out of State NP Academic Program Graduates:**

Recognized by Commission on Collegiate Nursing Education: YES [ ] NO [ ]

If yes, Name: __________________ Program Approval Cycle Dates:

I certify under penalty of perjury that the documentation regarding the completion of the nurse practitioner academic program for the above named applicant is true and correct.

**Signature:** __________________ (Date)
VERIFICATION OF NURSE PRACTITIONER CERTIFICATION BY NATIONAL ORGANIZATION/ASSOCIATION

METHOD 2

TO BE COMPLETED BY APPLICANT: Please complete Section A and submit to the applicable national organization/association to verify your nursing practitioner certification status. A fee is required by the national organization/association for the processing of the verification form.

A. TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
</tr>
</thead>
</table>

ADDRESS: Number & Street

City

State

Country

Postal/Zip Code

TELEPHONE NUMBER:

Home

Alternate

E-MAIL ADDRESS:

NAME OF ACADEMIC PROGRAM:

DATE OF BIRTH: (Month/Day/Year)

US SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:

PREVIOUS NAMES: (Including Maiden)

MOTHER'S MAIDEN NAME: (If One Only)

CALIFORNIA LICENSE NUMBER:

CERTIFICATION DATE:

SPECIALTY:

SIGNATURE OF APPLICANT: ______________________

DATE: ____________

B. TO BE COMPLETED BY THE CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

<table>
<thead>
<tr>
<th>NAME OF CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION</th>
<th>TELEPHONE NUMBER: ( )</th>
</tr>
</thead>
</table>

ADDRESS: Number & Street

City

State

Postal/Zip Code

METHOD OF CERTIFICATION:

CERTIFICATE NUMBER:

ORIGINAL DATE OF CERTIFICATION:

NURSE PRACTITIONER SPECIALTY AREA:

CURRENT RENEWAL CYCLES FOR CERTIFICATION/RECERTIFICATION:

(If not applicable, please explain)

From: ___________________ To: ___________________

(Month/Year) (Month/Year)

I certify under penalty of perjury that the documentation regarding the nurse practitioner certification status for the above named applicant is true and correct.

SIGNATURE: ________________________ (OFFICIAL SEAL) TITLE: ________________________ (DATE)

(Rev. 12/2010)
Verification of the applicant's clinical competency in the delivery of primary care is one of the requirements which must be met in order to qualify to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education, and the diagnosis and treatment of acute and chronic illnesses in a variety of practice settings. (California Code of Regulations Section 1480(c)).

CLINICALLY COMPETENT means the individual possesses and exercises the degree of knowledge, skill, and expertise ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the practice of primary care. (California Code of Regulations Section 1480(c)).

The verifying nurse practitioner and physician MUST meet the following requirements:
1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.

A. TO BE COMPLETED BY APPLICANT

B. TO BE COMPLETED BY THE EVALUATING "NURSE PRACTITIONER"

I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary care.
VERIFICATION OF “CLINICAL COMPETENCY” AS A NURSE PRACTITIONER

METHOD 3 - EQUIVALENCY

Verification of the applicant's clinical competency in the delivery of primary care is one of the requirements, which must be met in order to qualify to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients of all ages, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patients' health and the diagnosis and treatment of acute and chronic illnesses in a variety of practice settings. (California Code of Regulations Section 14808)

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, skill, and expertise required for the possession and exercise by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the practice of primary care. (California Code of Regulations Section 148080(a)).

The verifying nurse practitioner and physician MUST meet the following requirements:
1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.

A. TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER IDENTIFICATION NUMBER:</th>
<th>DATE OF BIRTH: (Month/Day/Year)</th>
<th>CALIFORNIA RN LICENSE NUMBER:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

SIGNATURE OF APPLICANT: ______________________ DATE: __________

B. TO BE COMPLETED BY THE EVALUATING "PHYSICIAN"

The above applicant has applied for a nurse practitioner evaluation in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
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</table>

<table>
<thead>
<tr>
<th>ADDRESS OF AGENCY: Number &amp; Street</th>
<th>City</th>
<th>State</th>
<th>Postal/Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>TELEPHONE NUMBER:</th>
<th>U.S. SOCIAL SECURITY NUMBER:</th>
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<table>
<thead>
<tr>
<th>MD LICENSE NUMBER:</th>
<th>EXPIRATION DATE:</th>
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</table>

<table>
<thead>
<tr>
<th>DATES EMPLOYED IN SPECIALTY AREA:</th>
<th>PROFESSIONAL SPECIALTY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From: ____________________ To: ____________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>METHOD(S) UTILIZED TO EVALUATE APPLICANT’S CLINICAL COMPETENCY:</th>
<th>PERIOD OF CLINICAL EVALUATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From: ____________________ To: ____________________</td>
</tr>
</tbody>
</table>

I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary care.

SIGNATURE OF EVALUATOR: ______________________ DATE: ____________________
VERIFICATION OF "CLINICAL EXPERIENCE" AS A NURSE PRACTITIONER

METHOD 3 - EQUIVALENCY

Verification of the nurse's clinical experience in the delivery of primary care is required in order for him/her to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education and the diagnosis and treatment of acute and chronic illnesses in a variety of practice settings. (California Code of Regulations Section 14806).

CLINICALLY COMPETENT means the individual possesses and exercises the knowledge, skill, care and experience ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care (California Code of Regulations Section 14806(a)).

The verifying nurse practitioner and physician MUST meet the following requirements:
1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.

A. TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
</tr>
</thead>
</table>

U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: ______________________

DATE OF BIRTH: (Month/Day/Year) ______________________

CALIFORNIA RN LICENSE NUMBER: ______________________

SIGNATURE OF APPLICANT: ______________________

DATE: ______________________

B. TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER VERIFYING THE APPLICANT'S CLINICAL EXPERIENCE

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

<table>
<thead>
<tr>
<th>NAME OF AGENCY:</th>
<th></th>
</tr>
</thead>
</table>

ADDRESS OF AGENCY: Number & Street: ______________________

City: ______________________ State: ______________________ Postal/Zip Code: ______________________

<table>
<thead>
<tr>
<th>NAME OF APPLICANT'S SUPERVISOR:</th>
<th>SUPERVISOR'S TELEPHONE NUMBER:</th>
</tr>
</thead>
</table>

SUPERVISOR'S TITLE: ______________________

LICENSE NUMBER: ______________________

EXPIRATION DATE: ______________________

DATES OF SUPERVISED CLINICAL EXPERIENCE:

From: ______________________ To: ______________________

From: ______________________ To: ______________________

From: ______________________ To: ______________________

SPECIALTY AREA: ______________________

NUMBER OF HOURS: ______________________ CLINICAL SPECIALITY: ______________________

I certify under penalty of perjury that I have verified that the above named applicant received the number of supervised clinical hours in the appropriate discipline in clinical practice in the performance of diagnostic and treatment procedures essential to the provision of primary care.

SIGNATURE OF SUPERVISOR: ______________________

DATE: ______________________

(Rev. 03/2016)
INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>BOARD OF REGISTERED NURSING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of official responsible for information maintenance:</td>
<td>EXECUTIVE OFFICER</td>
</tr>
<tr>
<td>Address:</td>
<td>P.O. BOX 944210, SACRAMENTO, CA 94244-2100</td>
</tr>
<tr>
<td>Phone Number</td>
<td>(916) 322-3350</td>
</tr>
<tr>
<td>Authority which authorizes the maintenance of the information:</td>
<td>SECTION 30, SECTION 2732.1(a), BUSINESS AND PROFESSIONS CODE</td>
</tr>
</tbody>
</table>

All information is mandatory.

The consequences, if any, of not providing all or any part of the requested information:

FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.

The principal purpose(s) for which the information is to be used:

TO DETERMINE ELIGIBILITY FOR LICENSURE. YOUR U.S. SOCIAL SECURITY NUMBER/ITIN WILL BE USED FOR PURPOSES OF LAW ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS, SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 94-455 (42 USC SECTION 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR U.S. SOCIAL SECURITY NUMBER/ITIN. IF YOU FAIL TO DISCLOSE YOUR U.S. SOCIAL SECURITY NUMBER/ITIN, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A $100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST IF AND WHEN YOU BECOME LICENSED.

Any known or foreseeable interagency or intergovernmental transfer which may be made of the information:

POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S. SOCIAL SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.

EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.
MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a “Mandated Reporter” for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Penal Code Section 11166 and will comply with those provisions.

California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 (generally law enforcement agencies) whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicably possible by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine not more than one thousand dollars ($1,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11166 and subsequent sections.
APPLICATION FOR TEMPORARY NURSE PRACTITIONER (NP) CERTIFICATE

INSTRUCTIONS:

1. The application fee for the Temporary Nurse Practitioner Certificate (TC/NP) is $35.00.

2. The TC/NP will not be issued until the Application for Nurse Practitioner Certification is complete with exception of criminal record clearance from the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).

3. The TC/NP will not be mailed to an in-care-of address or a third party.

4. Possession of a current and active California Temporary RN License (TL) is required.

PLEASE NOTE: IF YOU ALREADY POSSESS A PERMANENT CALIFORNIA RN LICENSE, YOU ARE NOT ELIGIBLE FOR THE TEMPORARY NURSE PRACTITIONER CERTIFICATE (TC/NP) AND YOUR APPLICATION FEE FOR THE TC/NP WILL NOT BE REFUNDED.

TO BE COMPLETED BY APPLICANT

(PRINT OR TYPE)

LAST NAME: ___________________ FIRST NAME: ___________________ MIDDLE NAME: ___________________

ADDRESS: ___________________ Number & Street ___________________ DATE OF BIRTH: (Month/Day/Year)

City ___________________ State ___________________ Country ___________________ Postal/Zip Code ____________

U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER: ___________________

TELEPHONE NUMBER: ___________________ Home ___________________ Alternate ___________________

E-MAIL ADDRESS: ___________________

PREVIOUS NAMES: (Including Maiden) ___________________

MOTHER'S MAIDEN NAME: (Last Name Only) ___________________

TEMPORARY RN LICENSE NUMBER: ___________________ EXPIRATION DATE: ___________________

NAME OF NURSE PRACTITIONER ACADEMIC PROGRAM: ___________________

ADDRESS: ___________________ Number & Street ___________________ City ___________________ State ___________________ Postal/Zip Code ____________

TYPE OF PROGRAM:  

☐ CERTIFICATE  ☐ MASTERS  ☐ POST-MASTERS

SPECIALTY: ___________________

ENTRANCE DATE: _________ (Month/Day/Year)  COMPLETION DATE: _________ (Month/Day/Year)

I certify under penalty of perjury that the above information regarding the Application for the Temporary Nurse Practitioner Certificate is true and correct.

SIGNATURE OF APPLICANT: ___________________ DATE: _________

(Rev. 06/02/18)
INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

| Agency Name: | BOARD OF REGISTERED NURSING |
| Title of official responsible for information maintenance: | EXECUTIVE OFFICE |
| Address: | P.O. BOX 944210, SACRAMENTO, CA 94244-2100 |
| Telephone Number | (916) 322-3350 |
| Authority which authorizes the maintenance of the information: | SECTION 30, SECTION 2732.1(a), BUSINESS AND PROFESSIONS CODE |

ALL INFORMATION IS MANDATORY!

The consequences, if any, of providing all or any part of the requested information:

FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.

The principal purpose(s) for which the information is to be used:

TO DETERMINE ELIGIBILITY FOR LICENSURE. YOUR U.S. SOCIAL SECURITY NUMBER/ITIN WILL BE USED FOR PURPOSES OF LAW ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 101-465 (42 USC SECTION 455(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR U.S. SOCIAL SECURITY NUMBER/ITIN. IF YOU FAIL TO DISCLOSE YOUR U.S. SOCIAL SECURITY NUMBER/ITIN, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A $100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST IF AND WHEN YOU BECOME LICENSED.

Any known, foreseeable interagency or intergovernmental transfer which may be made of the information:

POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S. SOCIAL SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.

EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.
MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a "Mandated Reporter" for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Penal Code Section 11166 and will comply with those provisions.

California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11166.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicably possible by telephone, and the mandated reporter must prepare and send a written report thereof within 48 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of not more than three thousand dollars ($3,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11166 and subsequent sections.
NURSE PRACTITIONER FURNISHING NUMBER APPLICATION

APPLICATION FEE - $400.00

PERSONAL DATA (PRINT OR TYPE)

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
</tr>
</thead>
</table>

ADDRESS: Number & Street

City

STATE Zip Code

DATE OF BIRTH: (Month/Day/Year)

TELEPHONE NUMBER:

Home ( ) Alternate ( )

PREVIOUS NAMES (Including Maiden)

MOTHER'S MAIDEN NAME (Last Name Only)

CA RN LICENSE NUMBER:

CA NP NUMBER:

NP SPECIALTY:

NURSE PRACTITIONER ADVANCED PHARMACOLOGY COURSE

NAME OF NURSE PRACTITIONER PROGRAM

COURSE TITLE

COMPLETION DATE:

# QTR/SEM UNITS:

NAME OF ACADEMIC COURSE:

SCHOOL ADDRESS: Number & Street

City

STATE Zip Code

I certify, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

SIGNATURE OF APPLICANT: ____________________________ DATE: ____________________________

** U.S. SOCIAL SECURITY NUMBER/ITIN DISCLOSURE STATEMENT

Disclosure of your U.S. Social Security Number/ITIN is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USC section 405(c)(3)(C)) authorizes collection of your U.S. Social Security Number/ITIN. Your U.S. Social Security Number/ITIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with section 17250 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and whose licensure is demonstrable with the requesting state. If you fail to disclose your U.S. Social Security Number/ITIN, your application for initial or renewed license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.
NURSE PRACTITIONER
ADVANCED PHARMACOLOGY COURSE VERIFICATION

In order to furnish drugs and/or devices pursuant to Business and Professions Code, Section 2836.1, the Nurse Practitioner must complete a California Board of Registered Nursing approved advanced pharmacology course. The criteria for the advanced pharmacology course is listed on the two (2) page attachment.

TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ADDRESS: Number & Street

City

State

Zip Code

DATE OF BIRTH: (Month/Day/Year)

TELEPHONE NUMBER:

Home ( )

Alternate ( )

PREVIOUS NAMES: (Include Maiden) (Include Name)

MOTHER'S MAIDEN NAME: (Last Name Only)

CALIFORNIA RN LICENSE NUMBER:  

CA NP NUMBER:  

DATES COURSE WAS TAKEN:

SIGNATURE OF APPLICANT: __________________

DATE: __________

TO BE COMPLETED BY THE DIRECTOR OF THE NURSE PRACTITIONER ACADEMIC PROGRAM

The above applicant has applied for a Nurse Practitioner furnishing number in California. You must provide the following information and mail to the California Board of Registered Nursing at the above address. The criteria for the advanced pharmacology course is listed on the two (2) page attachment.

NAME OF NURSE PRACTITIONER PROGRAM:  

ADDRESS: Number & Street

City

State

Zip Code

TELEPHONE NUMBER:

ADVANCED PHARMACOLOGY COURSE/CONTENT:

Entrance and completion dates for course:

Entrance: ____________________ (Month/Day/Year)

Completion: ____________________ (Month/Day/Year)

Was a separate course? □ YES □ NO

If YES, specify the course title: ____________________

Was the course integrated in the program curriculum? □ YES □ NO

Equivalent to: 3 quarter units: □ YES □ NO  

5 quarter units: □ YES □ NO 45 hours: □ YES □ NO

The drugs or devices are furnished or ordered by a Nurse Practitioner in accordance with standardized procedures or protocols developed when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained. □ YES □ NO

The Advanced Pharmacology course includes the key points and course objectives listed on the two (2) page attachment. □ YES □ NO

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

SIGNATURE: ____________________  

DATE: ____________________  

TITLE: ____________________
NURSE PRACTITIONER ADVANCED PHARMACOLOGY COURSE FOR FURNISHING

These revised guidelines are established for Nurse Practitioner programs who offer advanced pharmacology courses in order to meet Furnishing requirements.

MINIMUM COURSE OFFERINGS

- A post-RN licensure advanced pharmacology course based on the student's previous knowledge of pharmacology and pharmacotherapeutics.
- A three (3) semester units or five (5) quarter units academic course.

KEY POINTS:

The advanced pharmacology course must include:

- The mechanism for ongoing communication between the student and clinical instructor.
- The requirements for approved standardized procedures to begin pharmacotherapy practice.
- The requirement to furnish drugs/devices pursuant to a standardized procedure.
  - The furnishing responsibility for Schedule II, III, IV, V controlled substances that are to be furnished with a patient-specific protocol in compliance with the Health and Safety Code (HSC) Division 10, Uniformly Controlled Substances Act, Sections 11010-11651, Chapter 1, General Provisions and Definitions, for Nurse Practitioners.
  - The furnishing responsibility for Schedule II, III, IV and V controlled substances that are to be furnished with a patient-specific protocol in compliance with Health and Safety Code (HSC) Division 10, Uniformly Controlled Substances Act, Section 1115, for Certified Nurse Midwives.

COURSE OBJECTIVES:

1. Uses the data base obtained from the health assessment of the client to identify an appropriate therapeutic regimen, including drugs and/or devices.
2. Uses knowledge of pharmacokinetics when developing a therapeutic regimen that maximizes the therapeutic effect and minimizes adverse reactions.
3. Uses knowledge of pharmacodynamics to observe the effects of drugs and/or devices on the client; to predict the client's response; and to understand the effects of the drugs and/or devices.
4. Evaluates the response and compliance of the client to the drugs and/or devices and implements appropriate action.
   - Provides appropriate client education regarding the furnished drugs and/or devices.
5. Furnishes drugs and/or devices pursuant to standardized procedures and in conformance with applicable laws, rules and regulations.
6. Develops appropriate guidelines for the pharmacological management of selected health care syndromes/diseases commonly encountered with awareness of client's nutrition, culture, ethnicity and socioeconomic status.
7. Uses knowledge and awareness of the role of herbal and natural remedies while treating disease states.
Advanced Pharmacology Enabling Objectives have been developed through public input and are available upon request.

FACULTY QUALIFICATIONS
All stated qualifications must be met by the faculty, including Directors and instructors.
- Current, valid, and clear license to practice in the appropriate discipline.
- Demonstrates expertise in the theoretical and clinical aspects of pharmacology/pharmacotherapeutics.
- Possesses at least two years of experience in the teaching of advanced pharmacology.
- Includes a faculty member who has completed a doctoral level pharmacology/pharmacotherapeutics degree.
- Demonstrates evidence of advanced clinical practice within the past five years applying the principles of advanced pharmacology.

ADVANCED PHARMACOLOGY ENABLING OBJECTIVES
- Defines and verbalizes an understanding of the terminology of advanced pharmacology. (Vocabulary list to be included)
- Identifies sources of drugs and provides examples of drugs and each drug source.
- Describes the "targets" of drugs.
- Describes the pharmacokinetic process of absorption, distribution, metabolism, and excretion.
- Identifies factors that alter the processes of absorption, distribution, metabolism, and excretion.
- Analyzes how the body's acid base environment affects the pharmacokinetic process of absorption, distribution, metabolism, and excretion.
- Describes variables that determine therapeutic dosages of drugs.
- Defines half-life and explains the importance of a drug's half-life in a therapeutic drug regimen.
- Describes factors that influence a drug's half-life.
- Analyzes the relationship between drugs and their physiological and pathophysiological responses.
- Understands the pharmacokinetic and pharmacodynamic effects of broad categories of drugs, i.e., antibiotics, antihypertensives, anti-hyperlipidemics, etc. used in specific treatment regimens.
- Uses data obtained during a client's history and Physical Examination (H&P) to identify appropriate drug choice/s and herbs, vitamins, minerals, trace elements, etc., and recognizes the role of herbal and alternative remedies in the treatment of health problems.
- Based upon the principles of pharmacodynamics and pharmacokinetics, identifies the indications, rationale, and mechanism of actions and contrasts drugs used to treat specific conditions.
- Understands the potential interactions between drugs and herbs, vitamins, minerals, and trace elements.
- Performs appropriate monitoring before, during, and after specific drug regimens.
- Monitors effectiveness of drugs, evaluates the response and compliance of the client to the drugs/devices and identifies intervention when side effects, and monitors adverse events that may occur.
- Identifies drugs within the normal therapeutic range.
- Identifies appropriate methods to write and transmit prescriptions.
- Furnishes drugs pursuant to applicable legal requirements, standardized procedures, and ethical standards.
- Identifies sources for drug information and uses the resources to maintain clinical competency for clinical decision making.
- Demonstrates the essential components of client education re: medications including: name of medication/s frequency/time of dosage, correct dosage/s to take, how to take the medication/s i.e., with or without food, what to do if a dose of a medication is missed, side effects to expect, and adverse event/s to report to the prescriber.
- Identifies factors that influence medication compliance.
- Provides comprehensive and appropriate client and family education re: drugs of choice and alternatives and involves the client and family in the decision-making process re: drug treatments.
- Chooses most appropriate drug for a disease based upon client's symptomatology, health status and lifestyle.
# INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>BOARD OF REGISTERED NURSING</th>
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</thead>
<tbody>
<tr>
<td>Title of official responsible for information maintenance:</td>
<td>EXECUTIVE OFFICER</td>
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<tr>
<td>Address:</td>
<td>P.O. BOX 944210, SACRAMENTO, CA 94244-2100</td>
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<td>Telephone Number:</td>
<td>(916) 322-3350</td>
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</tbody>
</table>

Authority which authorizes the maintenance of the information:

SECTION 30, SECTION 2732.1(a), BUSINESS AND PROFESSIONS CODE

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Any known or foreseen interagency or intergovernmental transfer which may be made of the information:

POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S.社會 SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.

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MANDATORY REPORTER

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California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as practicably possible by telephone, and the mandated reporter must prepare and send a written report thereof within 24 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11164, and subsequent sections.
APPLICATION FOR NURSE PRACTITIONER (NP) CERTIFICATION

APPLICATION FEE - $500.00

PERSONAL DATA (PRINT OR TYPE)

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
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<table>
<thead>
<tr>
<th>ADDRESS:</th>
<th>Number and Street</th>
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<table>
<thead>
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<th>City</th>
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<th>Country</th>
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<th>HOME TELEPHONE NUMBER:</th>
<th>ALTERNATE TELEPHONE NUMBER:</th>
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<table>
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<th>DATE OF BIRTH: (Month/Day/Year)</th>
<th>U.S. SOCIAL SECURITY NUMBER</th>
<th>PREVIOUS NAMES: (Including Maiden)</th>
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</table>

<table>
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<tr>
<th>MOTHER’S MAIDEN NAME: (Last Name Only)</th>
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</table>

RN LICENSURE/NURSE PRACTITIONER CERTIFICATION

<table>
<thead>
<tr>
<th>California RN License Number:</th>
<th>List All States Where You Hold/Held an RN License and Status:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date Issued</th>
<th>Expiration Date:</th>
</tr>
</thead>
</table>

| List ALL States Where You Hold/Held a Nurse Practitioner License/Certificate and Status: |

RN EDUCATION

<table>
<thead>
<tr>
<th>Name of Professional Registered Nursing Program</th>
<th>Type of Program:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>ASSOCIATE DEGREE</th>
<th>DIPLOMA</th>
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<table>
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<tr>
<th>BACCALAUREATE DEGREE</th>
<th>MASTERS DEGREE/NURSING</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Country</th>
</tr>
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</table>

<table>
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<tr>
<th>Entrance Date:</th>
<th>Graduation/Completion Date:</th>
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</table>

NURSE PRACTITIONER EDUCATION

<table>
<thead>
<tr>
<th>Name of Nurse Practitioner Academic Program</th>
<th>Type of Nurse Practitioner Academic Program:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CERTIFICATE</th>
<th>MASTERS</th>
<th>POST-MASTERS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Area of Specialization:</th>
<th>Entrance Date:</th>
<th>Graduation/Completion Date:</th>
</tr>
</thead>
</table>

(Rev. 03/2016)
NAME OF APPLICANT: __________________________________________________________

NURSE PRACTITIONER PROFESSIONAL CERTIFICATION (If Applicable):

METHOD OF CERTIFICATION:
☐ EXAMINATION
☐ OTHER (Please Explain):

Name of Organization/Association

Area of Specialization: ___________________________

Certification Number: ___________________________

Original Date of Certification: ____________________

Current Recertification Cycle Dates: ______________

BACKGROUND INFORMATION

Have you applied for a Nurse Practitioner certificate in California? If yes, name on previous application: __________________________

Have you ever been issued a Nurse Practitioner certificate in California? If yes, STOP! DO NOT CONTINUE. Please contact the Board regarding whether you should apply or file a petition for reinstatement of your California Nurse Practitioner certificate.

Have you ever had disciplinary proceedings against any license as a nurse or any health-care related license or certificate including revocation, suspension, probation, voluntary surrender against any other proceeding in any state or country? If yes, please provide a detailed written explanation, including the date and state or country where the discipline occurred.

Have you ever been convicted of any offense other than a traffic violation? Please explain fully as described in the application instructions. Offenses must be reported even if they have been acquitted, dismissed, or expunged or if a diversion program has been completed. These offenses are driving under the influence, injury to persons or providing false information that may be reported. The definition of conviction includes plea of nolo contendere (no contest), as well as plea of guilty. YOU MUST INCLUDE ALL FELONY CONVICTIONS.

I understand that I am required to report immediately to the California Board of Registered Nursing if I am convicted of ANY offense that occurs between the date of this application and the date that a California registered nurse license is issued. I am also required to report to the California Board of Registered Nursing if I have any disciplinary action and/or voluntary surrender against ANY health-care related license/certificate that occurs between the date of this application and the date that a California registered nurse license is issued. I understand that failure to do so may result in denial of application or subsequent disciplinary action against my license/certificate.

I certify, under penalty of perjury under the laws of the State of California, that all information provided in connection with the application for licensure is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure or license revocation in California.

SIGNATURE OF APPLICANT ___________________________ DATE ______________

Attach a recent 2"x2" passport type photograph.

Please tape on all four sides.

Head and shoulders only

** U.S. SOCIAL SECURITY NUMBER/TIN DISCLOSURE STATEMENT

Disclosure of your U.S. Social Security Number/TIN is mandatory. Section 23 of the Insurance and Protectors Code and Public Law 94-455 (42 USC section 409(a)(2)(C)) authorizes collection of your U.S. Social Security Number/TIN. Your U.S. Social Security Number/TIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in coordination with section 17609 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocated with the requesting state. If you fail to disclose your U.S. Social Security Number/TIN, your application for initial or renewed license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

rev. 3/2019
VERIFICATION OF NURSE PRACTITIONER ACADEMIC PROGRAM

TO BE COMPLETED BY APPLICANT: Please complete Section A and forward to the program director/representative for the nurse practitioner academic program for completion. Official transcripts submitted must include all completed coursework with the certificate/degree status conferred and must be sent directly to the Board of Registered Nursing by the Registrar's Office/Transcript Office. A processing fee may be required for the submission of official transcripts.

A. TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
</tr>
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</table>

ADDRESS: Number & Street

DATE OF BIRTH: (Month/Day/Year)

City

State

Country

Postal/Zip Code

U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:

TELEPHONE NUMBER:

Home ( )

Alternate ( )

E-MAIL ADDRESS:

CALIFORNIA LICENSE NUMBER:

EXPIRATION DATE:

NAME OF ACADEMIC PROGRAM:

SPECIALTY:

SIGNATURE OF APPLICANT: ___________________________ DATE: ___________________________

(PRINT OR TYPE)

B. TO BE COMPLETED BY THE PROGRAM DIRECTOR/REPRESENTATIVE FOR THE NURSE PRACTITIONER ACADEMIC PROGRAM

The above applicant has applied for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

NAME OF NURSE PRACTITIONER ACADEMIC PROGRAM:

TELEPHONE NUMBER: ( )

ADDRESS: Number & Street

City

State

Postal/Zip Code

TYPE OF PROGRAM:

☐ CERTIFICATE

☐ MASTERS

☐ POST-MASTERS

SPECIALTY: ___________________________

ENTRY DATE: (Month/Day/Year)

COMPLETION DATE: (Month/Day/Year)

Date Certificate/Degree Status Confirmed: (Month/Day/Year)

OUT OF STATE NP ACADEMIC PROGRAM GRADUATES:

Recognized by Commission on Collegiate Nursing Education: ☐ YES ☐ NO

If yes, Name: ___________________________

Program Approval Cycle Dates: ___________________________

I certify under penalty of perjury that the documentation regarding the completion of the nurse practitioner academic program for the above named applicant is true and correct.

SIGNATURE: ___________________________ DATE: ___________________________ TITLE: ___________________________
VERIFICATION OF NURSE PRACTITIONER CERTIFICATION BY NATIONAL ORGANIZATION/ASSOCIATION

METHOD 2

TO BE COMPLETED BY APPLICANT: Please complete Section A and submit to the applicable national organization/association to verify your nursing practitioner certification status. A fee is required by the national organization/association for the processing of the verification form.

A. TO BE COMPLETED BY APPLICANT

<table>
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<th>PRINT OR TYPE</th>
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<td>LAST NAME:</td>
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<td>DATE OF BIRTH: (Month/Day/Year)</td>
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<td>Alternate</td>
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<tr>
<td>E-MAIL ADDRESS:</td>
</tr>
<tr>
<td>NAME OF ACADEMIC PROGRAM:</td>
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<tr>
<td>DATE:</td>
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</table>

B. TO BE COMPLETED BY THE CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION

The above applicant has applied for a nurse practitioner certification renewal. Please provide the following information and mail to the Board of Registered Nursing at the above address.

| NAME OF CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION: |
| TELEPHONE NUMBER: ( ) |
| ADDRESS: |
| Number & Street |
| City |
| State |
| Postal/Zip Code |
| METHOD OF CERTIFICATION: |
| CERTIFICATION NUMBER: |
| ORIGINAL DATE OF CERTIFICATION: |
| NURSE PRACTITIONER SPECIALTY: |
| CURRENT RENEWAL CYCLE DATES FOR CERTIFICATION/RECERTIFICATION: |
| From: (Month/Year) To: (Month/Year) |

I certify under penalty of perjury that the documentation regarding the nurse practitioner certification status for the above named applicant is true and correct.

SIGNATURE: ___________________________ (DATE) TITLE: ___________________________ 

(EDITORIAL NOTATION)
**VERIFICATION OF “CLINICAL COMPETENCY” AS A NURSE PRACTITIONER**

**METHOD 3 - EQUIVALENCY**

Verification of the applicant's clinical competency in the delivery of primary care is one of the requirements, which must be met in order to qualify to use the title “Nurse Practitioner” in California.

**PRIMARY CARE** means comprehensive and continuous care provided to patients, families, and their community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education and the diagnosis and treatment of acute and chronic illnesses in a variety of practice settings. (*California Code of Regulations Section 1480(c)*).

**CLINICALLY COMPETENT** means the individual possesses and exercises the degree of training, skill, care and judgment ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner specialty. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care. (*California Code of Regulations Section 1480(c)*).

The verifying nurse practitioner and physician MUST meet the following requirements:
1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.

### A. TO BE COMPLETED BY APPLICANT

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<tr>
<th>U.S. SOCIAL SECURITY NUMBER:</th>
<th>INDIVIDUAL TAXPAYER IDENT NUMBER:</th>
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<tr>
<th>DATE OF BIRTH: (Month/Day/Year)</th>
<th>CALIFORNIA RN LICENSE NUMBER:</th>
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</table>

**SIGNATURE OF APPLICANT:** _______________________ **DATE:** __________

### B. TO BE COMPLETED BY THE EVALUATING “NURSE PRACTITIONER”

The above applicant has applied for nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address:

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
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<th>ADDRESS OF AGENCY: Number &amp; Street</th>
<th>City</th>
<th>State</th>
<th>Postal/Zip Code</th>
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<th>TELEPHONE NUMBER:</th>
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<tr>
<th>RN LICENSE NUMBER:</th>
<th>DATES EMPLOYED IN SPECIALTY AREA:</th>
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<td>From: _____ To: _____</td>
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<tr>
<th>NP CERTIFICATION NUMBER:</th>
<th>PROFESSIONAL SPECIALTY:</th>
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METHOD(S) UTILIZED TO EVALUATE APPLICANT’S CLINICAL COMPETENCY: PERIOD OF CLINICAL EVALUATION:

<table>
<thead>
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<th>From: (Month/Year) To: (Month/Year)</th>
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</table>

I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary care.

**SIGNATURE OF EVALUATOR:** _______________________ **DATE:** __________
**VERIFICATION OF "CLINICAL COMPETENCY" AS A NURSE PRACTITIONER**

**METHOD 3 - EQUIVALENCY**

Verification of the applicant's clinical competency in the delivery of primary care is one of the requirements, which must be met in order to qualify to use the title "Nurse Practitioner" in California.

**PRIMARY CARE** means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, health education and the diagnosis and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(i)).*

**CLINICALLY COMPETENT** means the individual possesses and exercised by a certified nurse practitioner providing healthcare in the same area of practice. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care. *(California Code of Regulations Section 1480(c)).*

The verifying nurse practitioner and physician MUST meet the following requirements:
1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.

### A. TO BE COMPLETED BY APPLICANT

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<th>LAST NAME:</th>
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<th>MIDDLE NAME:</th>
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<tr>
<th>U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:</th>
<th>DATE OF BIRTH: (Month/Day/Year)</th>
<th>CALIFORNIA RN LICENSE NUMBER:</th>
</tr>
</thead>
</table>

**SIGNATURE OF APPLICANT:** _________________________________

**DATE:**

### B. TO BE COMPLETED BY THE EVALUATING "PHYSICIAN"

The above applicant is applying for nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

<table>
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<th>LAST NAME:</th>
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<tr>
<th>MD LICENSE NUMBER:</th>
<th>EXPIRATION DATE:</th>
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<tr>
<th>DATES EMPLOYED IN SPECIALTY AREA:</th>
<th>PROFESSIONAL SPECIALTY:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY:</th>
<th>PERIOD OF CLINICAL EVALUATION:</th>
</tr>
</thead>
</table>

From: ___________ To: ___________

**FROM:** mass. Year **TO:** mass. Year

I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary care.

**SIGNATURE OF EVALUATOR:** _________________________________

**DATE:**

(Rev. 01/2019)
VERIFICATION OF "CLINICAL EXPERIENCE" AS A NURSE PRACTITIONER

METHOD 3 - EQUIVALENCY

Verification of the nurse’s clinical experience in the delivery of primary care is required in order for her to use the title "Nurse Practitioner" in California.

PRIMARY CARE means comprehensive and continuous care provided to patients, families, and the community. Primary care focuses on basic preventive care, health promotion, disease prevention, health maintenance, patient education, and the diagnosis and treatment of acute and chronic illnesses in a variety of practice settings. (California Code of Regulations Section 1480(c)).

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, skill, data, and experience ordinarily possessed and exercised by a certified nurse practitioner providing healthcare in the same nurse practitioner category. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary care. (California Code of Regulations Section 1480(c)).

The verifying nurse practitioner and physician MUST meet the following requirements:
1. Current, clear and active licensure to practice.
2. Clinical competency in the provision of primary care.
3. Direct observations of clinical practice.

A. TO BE COMPLETED BY APPLICANT

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<td>MIDDLE NAME:</td>
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<tr>
<td>U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:</td>
</tr>
<tr>
<td>DATE OF BIRTH: (Month/Day/Year)</td>
</tr>
<tr>
<td>CALIFORNIA RN LICENSE NUMBER:</td>
</tr>
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</table>

SIGNATURE OF APPLICANT: ___________________ DATE: ____________

B. TO BE COMPLETED BY THE PHYSICIAN / NURSE PRACTITIONER VERIFYING THE APPLICANT'S CLINICAL EXPERIENCE

The above application is required for a nurse practitioner certification in California. Please provide the following information and mail to the Board of Registered Nursing at the above address.

<table>
<thead>
<tr>
<th>NAME OF AGENCY:</th>
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<tr>
<td>ADDRESS OF AGENCY: Numeral Street City State Postal/Zip Code</td>
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<tr>
<td>NAME OF APPLICANT'S SUPERVISOR:</td>
</tr>
<tr>
<td>SUPERVISOR'S TITLE:</td>
</tr>
<tr>
<td>LICENSE NUMBER:</td>
</tr>
<tr>
<td>EXPIRATION DATE:</td>
</tr>
<tr>
<td>SUPERVISOR'S TELEPHONE NUMBER:</td>
</tr>
<tr>
<td>DATES OF SUPERVISOR'S EMPLOYMENT:</td>
</tr>
<tr>
<td>From: ____________ To: ____________</td>
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<tr>
<td>SPECIALTY AREA:</td>
</tr>
<tr>
<td>DATES OF SUPERVISED CLINICAL EXPERIENCE:</td>
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<td>From: ____________ To: ____________</td>
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<td>From: ____________ To: ____________</td>
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<tr>
<td>From: ____________ To: ____________</td>
</tr>
<tr>
<td>NUMBER OF HOURS:</td>
</tr>
<tr>
<td>CLINICAL SPECIALTY:</td>
</tr>
</tbody>
</table>

I certify under penalty of perjury that I have verified that the above named applicant received the number of supervised clinical hours in the appropriate discipline in clinical practice in the performance of diagnostic and treatment procedures essential to the provision of primary care.

SIGNATURE OF SUPERVISOR: ___________________ DATE: ____________

(rev. 03/2016)
INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>BOARD OF REGISTERED NURSING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of official responsible for information maintenance:</td>
<td>EXECUTIVE OFFICER</td>
</tr>
<tr>
<td>Address:</td>
<td>P.O. BOX 944210, SACRAMENTO, CA 94244-2100</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>(916) 322-3350</td>
</tr>
<tr>
<td>Authority which authorizes the maintenance of the information:</td>
<td>SECTION 30, SECTION 2732, BUSINESS AND PROFESSIONS CODE</td>
</tr>
</tbody>
</table>

ALL INFORMATION IS MANDATORY.

The consequences of not providing all or any part of the requested information:

FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.

The principal purpose(s) for which the information is to be used:

TO DETERMINE ELIGIBILITY FOR LICENSURE, YOUR U.S. SOCIAL SECURITY NUMBER/ITIN WILL BE USED FOR PURPOSES OF TAX ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 93-645 (42 USC SECTION 405(e)(2)(C)) AUTHORIZE COLLECTION OF YOUR U.S. SOCIAL SECURITY NUMBER/ITIN. IF YOU FAIL TO DISCLOSE YOUR U.S. SOCIAL SECURITY NUMBER/ITIN, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A $100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST IF AND WHEN YOU BECOME LICENSED.

Any known unpreventable interagency or intergovernmental transfer which may be made of the information:

POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S. SOCIAL SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.

EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.
MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a “Mandated Reporter” for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Penal Code Section 11166 and will comply with those provisions.

California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11166.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicable possible by telephone, and the mandated reporter must prepare and send a written report therein within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor, punishable by up to six months in a county jail, a fine of one thousand dollars ($1,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11164, and subsequent sections.
APPLICATION FOR TEMPORARY NURSE PRACTITIONER (NP) CERTIFICATE

INSTRUCTIONS:

1. The application fee for the Temporary Nurse Practitioner Certificate (TC/NP) is $150.00.

2. The TC/NP will not be issued until the Application for Nurse Practitioner Certification is complete with exception of criminal record clearance from the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).

3. The TC/NP will not be mailed to an in-care-of address or an alternate address.

4. Possession of a current and active California Temporary RN License is required.

PLEASE NOTE: IF YOU ALREADY POSSESS A PERMANENT CALIFORNIA RN LICENSE, YOU ARE INELIGIBLE FOR THE TEMPORARY NURSE PRACTITIONER CERTIFICATE (TC/NP) AND YOUR APPLICATION FEE FOR THE TC/NP WILL NOT BE REFUNDED.

TO BE COMPLETED BY APPLICANT

(PRINT OR TYPE)

LAST NAME: ___________________________ FIRST NAME: ___________________________ MIDDLE NAME: ___________________________

ADDRESS: ________________________________ Number: ___________________________ STREET: ___________________________ CITY: ___________________________

STATE: ___________________________ POSTAL ZIP CODE: ___________________________

DATE OF BIRTH: (Month/Day/Year) ___________________________

U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:

TEMPORARY RN LICENSE NUMBER: ___________________________

EXPIRATION DATE: ___________________________

NAME OF NURSE PRACTITIONER ACADEMIC PROGRAM:

ADDRESS: ________________________________ Number: ___________________________ CITY: ___________________________ STATE: ___________________________

POSTAL ZIP CODE: ___________________________

TYPE OF PROGRAM:

☐ CERTIFICATE
☐ MASTERS
☐ POST-MASTERS

SPECIALTY: ___________________________

ENTRANCE DATE: ___________________________ (Month/Day/Year)

COMPLETION DATE: ___________________________ (Month/Day/Year)

I certify under penalty of perjury that the above information regarding the Application for the Temporary Nurse Practitioner Certificate is true and correct.

SIGNATURE OF APPLICANT: ___________________________ DATE: ___________________________
INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

<table>
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</tr>
<tr>
<td>Authority which authorizes the maintenance of information</td>
<td>SECTION 30, SECTION 2732.1(B) BUSINESS AND PROFESSIONS CODE</td>
</tr>
<tr>
<td>All information is mandatory.</td>
<td></td>
</tr>
</tbody>
</table>

The consequences of not providing all or any part of the requested information:

FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.

The principal purpose(s) for which the information will be used:

TO DETERMINE ELIGIBILITY FOR LICENSURE, YOUR U.S. SOCIAL SECURITY NUMBER/ITIN WILL BE USED FOR PURPOSES OF TAX ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE OR PUBLIC LAW 93-635 (2 USC SECTION 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR U.S. SOCIAL SECURITY NUMBER. IF YOU FAIL TO DISCLOSE YOUR U.S. SOCIAL SECURITY NUMBER/ITIN, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A $100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST AND WHEN YOU BECOME LICENSED.

Any known interagency or intergovernmental transfer which may be made of the information:

POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S. SOCIAL SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.

EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.
MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a “Mandated Reporter” for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Penal Code Section 11166 and will comply with those provisions.

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For further details about these requirements, consult Penal Code Section 11164, and subsequent sections.
NURSE PRACTITIONER FURNISHING NUMBER APPLICATION

APPLICATION FEE - $400.00

PERSONAL DATA (PRINT OR TYPE)

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<tr>
<th>LAST NAME:</th>
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<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

DATE OF BIRTH: (Month/Day/Year)

TELEPHONE NUMBER: Home ( ), Alternate ( )

PREVIOUS NAMES: (include maiden)

MOTHER'S MAIDEN NAME: [Last Name Only]

CA RN LICENSE NUMBER: 

CA NP NUMBER: 

NP SPECIALTY: 

NURSE PRACTITIONER ADVANCED PHARMACOLOGY COURSE

NAME OF NURSE PRACTITIONER PROGRAM

COURSE TITLE

COMPLETION DATE: 

# QTR/SEM UNITS: 

NAME OF ACADEMIC COURSE:

SCHOOL ADDRESS: Number & Street

City | State | Zip Code

I certify, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

SIGNATURE OF APPLICANT: ___________________________ DATE: __________

**U.S. SOCIAL SECURITY NUMBER/TIN DISCLOSURE STATEMENT

Disclosure of your U.S. Social Security Number/TIN is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USC section 406(4)(2)(C)) authorizes collection of your U.S. Social Security Number/TIN. Your U.S. Social Security Number/TIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocated with the requesting state. If you fail to disclose your U.S. Social Security Number/TIN, your application for initial or renewed license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

(Rev. 09/2010)
NURSE PRACTITIONER
ADVANCED PHARMACOLOGY COURSE VERIFICATION

In order to furnish drugs and/or devices pursuant to Business and Professions Code, Section 2836.1, the Nurse Practitioner must complete a California Board of Registered Nursing approved advanced pharmacology course. The criteria for the advanced pharmacology course is listed on the two (2) page attachment.

**TO BE COMPLETED BY APPLICANT**

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
</tr>
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<tbody>
<tr>
<td>ADDRESS:</td>
<td>NUMBER &amp; STREET</td>
<td>DATE OF BIRTH: (MONTH/DAY/YEAR)</td>
</tr>
<tr>
<td>CITY:</td>
<td>STATE:</td>
<td>COUNTRY:</td>
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**TELEPHONE NUMBER:**

Home ( )
Alternate ( )

**CALIFORNIA RN LICENSE NUMBER:**

CA NUMBER: DATES COURSE WAS TAKEN:

**SIGNATURE OF APPLICANT:** ________________________ DATE: ______________

**TO BE COMPLETED BY THE DIRECTOR OF THE NURSE PRACTITIONER ACADEMIC PROGRAM**

The above applicant has applied to furnish drugs or devices in California. Please provide the following information and mail to the California Board of Registered Nursing at the above address. The criteria for the advanced pharmacology course is listed on the two (2) page attachment.

**NAME OF NURSE PRACTITIONER PROGRAM:**

**TELEPHONE NUMBER:**

<table>
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<tr>
<th>ADDRESS:</th>
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<th>ZIP CODE:</th>
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**ADVANCED PHARMACOLOGY COURSE CONTENT:**

Entrance and completion dates for course:

Entrance: (MONTH/DAY/YEAR) Completion: (MONTH/DAY/YEAR)

Was a separate course? YES NO

If NO, specify the course title: ____________________________

If NO, was integrated in the program curriculum? YES NO

Equivalent to: 3 SEMESTER UNITS: YES NO 5 QUARTER UNITS: YES NO 45 HOURS: YES NO

The drugs or devices are furnished or ordered by a Nurse Practitioner in accordance with standardized procedures or protocols developed when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained. YES NO

The Advanced Pharmacology course includes the key points and course objectives listed on the two (2) page attachment. YES NO

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

**SIGNATURE:** ________________________  **TITLE:** ________________________  **DATE:** ________________________

(Rev. 06/2019)
NURSE PRACTITIONER ADVANCED PHARMACOLOGY COURSE FOR FURNISHING

These revised guidelines are established for Nurse Practitioner programs who offer advanced pharmacology courses in order to meet Furnishing requirements.

MINIMUM COURSE OFFERINGS

- A post-RN licensure advanced pharmacology course based on the RN's previous knowledge of pharmacology and pharmacotherapeutics.
- A three (3) semester units or five (5) quarter units academic course.

KEY POINTS:

The advanced pharmacology course must include:

- The mechanism for ongoing communication between the student and course instructor.
- The requirements for approved standardized procedures to be in place prior to beginning practice.
- The requirement to furnish substances pursuant to standardized procedure.
- The furnishing responsibilities for Schedule II, III, IV, V controlled substances that are to be furnished with a patient-specific protocol in compliance with the Health and Safety Code (HSC) Division 10, Uniform Controlled Substances Act, Sections 11000-11657, chapter 1, General Provisions and Definitions, for Nurse Practitioners.
- The furnishing responsibilities for Schedule II, III, IV, and V controlled substances that are to be furnished with a patient specific protocol in compliance with Health and Safety Code (HSC) Division 10, Uniform Controlled Substances Act, Section 11056, for Certified Nurse Midwives.

COURSE OBJECTIVES:

1. Uses the data base obtained from the health assessment of the client to identify an appropriate therapeutic regimen, including drugs and/or devices.
2. Uses knowledge of pharmacokinetics when developing a therapeutic regimen that maximizes the therapeutic effectiveness while minimizing adverse reactions.
3. Uses knowledge of pharmacodynamics to observe the effects of drugs and/or devices on a client; to predict the client's response; and to understand the effects of the drugs and/or devices.
4. Evaluates the response and compliance of the client to the drugs and/or devices and implements appropriate action.
5. Provides appropriate client education regarding the furnished drugs and/or devices.
6. Furnishes drugs and/or devices pursuant to standardized procedures and in conformance with applicable laws, codes, and/or regulations.
7. Examines appropriate guidelines for the pharmacological management of selected health care syndromes and diseases commonly encountered with awareness of client's nutrition, culture, ethnicity and socioeconomic status.
8. Uses knowledge and awareness of the role of herbal and natural remedies while treating disease states.
Advanced Pharmacology Enabling Objectives have been developed through public input and are available upon request.

FACULTY QUALIFICATIONS
All stated qualifications must be met by the faculty, include Directors and instructors.
- Current, valid and clear license to practice in the appropriate discipline.
- Demonstrates expertise in the theoretical and clinical aspects of pharmacology/pharmacotherapeutics.
- Possesses at least two years of experience in the teaching of advanced pharmacology.
- Includes a faculty member who has completed a doctoral level pharmacology/pharmacotherapeutics degree.
- Demonstrates evidence of advanced clinical practice within the past five years applying the principles of advanced pharmacology.

ADVANCED PHARMACOLOGY ENABLEING OBJECTIVES
- Defines and verbalizes an understanding of the terminology of advanced pharmacology. (Vocabulary list to be included)
- Identifies sources of drugs and provides examples of drugs from each drug source.
- Describes the "targets" of drugs.
- Describes the pharmacokinetic process of absorption, distribution, metabolism, and excretion.
- Identifies factors that alter the processes of absorption, distribution, metabolism, and excretion.
- Analyzes how the body's acid base environment affects the pharmacokinetic process of absorption, distribution, metabolism, and excretion of drugs.
- Describes variables that determine the bioavailability of drugs.
- Defines half-life and explains the relationship of drug's half-life to therapeutic drug regimen.
- Describes factors that influence a drug's half-life.
- Analyzes the relationship between drugs and their physiological and pathological responses.
- Understands the pharmacokinetic and pharmacodynamic effects of broad categories of drugs, i.e., antibiotics, antiarrhythmics, and antihypertensives, contraceptives, hormone replacement therapy, and specific treatment regimens.
- Uses data obtained during a physical examination to identify appropriate drug choice and alternatives, vitamins, minerals, and trace elements, regimens, and recognizes the role of herbal and supplements in the treatment of health and disease states.
- Based upon the principles of pharmacokinetics and pharmacodynamics, identifies the indications, rationales, and mechanism of actions of drugs and contrasts drugs used to treat specific conditions.
- Understands and potential interactions between drugs and foods, vitamins, minerals, and trace elements.
- Performs appropriate monitoring before starting, and during the drug regimen.
- Monitors efficacy of drug/s evaluates the response and compliance of the client to the drugs/devices and recognizes interventions, side effects, and changes adverse events that may occur.
- Identifies drugs with narrow therapeutic ranges.
- Identifies appropriate methods to write and transmit prescriptions.
- Practices in accordance with applicable legal requirements, standardized procedures, and ethical standards.
- Identifies resources for drug information and uses the resources to maintain clinical competency for furnishing.
- Describes the components of client education re: medications including: name of medication/s, frequency of dosing, contest in dosage/s to take, how to take the medication/s i.e., with or without food, what to do if a dose of a medication is missed, side effects to expect, and adverse event/s to report to the prescriber.
- Identifies factors that influence medication compliance.
- Provides comprehensive and appropriate client and family education re: drugs of choice and alternatives and involves the client and family in the decision making process re: drug treatments.
- Chooses most appropriate drug for a disease base upon client's symptomatology, health status and lifestyle.
INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals:

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>BOARD OF REGISTERED NURSING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of official responsible for information maintenance:</td>
<td>EXECUTIVE OFFICER</td>
</tr>
<tr>
<td>Address:</td>
<td>P.O. BOX 944210, SACRAMENTO, CA 94244-2100</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>(916) 322-3350</td>
</tr>
</tbody>
</table>

Authority which authorizes the maintenance of the information:
SECTION 30, SECTION 2732, BUSINESS AND PROFESSIONS CODE

ALL INFORMATION IS MANDATORY.

The consequence of not providing all or any part of the requested information:
FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.

The principal purpose(s) for which the information is to be used:
TO DETERMINE ELIGIBILITY FOR LICENSURE, YOUR U.S. SOCIAL SECURITY NUMBER/ITIN WILL BE USED FOR PURPOSES OF TAX ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 93-655 (42 USC SECTION 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR U.S. SOCIAL SECURITY NUMBER/ITIN. IF YOU FAIL TO DISCLOSE YOUR U.S. SOCIAL SECURITY NUMBER/ITIN, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A $100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST AND WHEN YOU BECOME LICENSED.

Any knowledge for possible interagency or intergovernmental transfer which may be made of the information:
POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING U.S. SOCIAL SECURITY NUMBER/ITIN TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.

EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.
MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a "Mandated Reporter" for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Penal Code Section 11166 and will comply with those provisions.

California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity and within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicable, either by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor, punishable by up to six months in a county jail or a fine of one thousand dollars ($1,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11164, and subsequent sections.