STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

GENERAL INSTRUCTIONS AND APPLICATION REQUIREMENTS FOR NURSE PRACTITIONER (NP) CERTIFICATION

GENERAL INSTRUCTIONS

I. GENERAL APPLICATION REQUIREMENTS

Nurse Practitioner certification eligibility requires the possession of an active California registered nurse (RN) license (California Code of Regulations, Section 1482).

If you do not possess an active California RN license and have never applied for a California RN license, an Application for California RN Licensure by Endorsement must also be submitted. If you have had a permanent California RN license, you must either renew or reactivate the California RN license.

Nurse Practitioner application fee is an earned fee; therefore, when an applicant is found ineligible the application fee is not refunded. Processing times for certification may vary, depending on the receipt of documentation from academic programs, associations/national organizations or evaluators. Processing a Nurse Practitioner certification application indicating a conviction(s) and/or disciplinary action(s) may take longer. A pending application file is not a disclosable public record; therefore, an applicant must sign a release of information before the Board of Registered Nursing will release information relating to NP application to the public, including employers, relatives or other third parties. Once you are certified, your address of record must be disclosed to the public upon request.

II. NAME AND/OR ADDRESS CHANGES

California Code of Regulations, Section 1409.1 requires that you notify the Board of Registered Nursing of all name and address changes within thirty (30) days of any change. You may call the Board of Registered Nursing regarding the change of address of record. If you have changed your name, please submit a letter of explanation along with legal documentation of the name change to the Board. Examples of acceptable forms of legal documentation are birth certificate, marriage certificate, divorce decree and/or court documents, social security card or passport. A copy of a driver's license is not acceptable.

III. SOCIAL SECURITY NUMBER & INDIVIDUAL TAXPAYER IDENTIFICATION NUMBER (ITIN)

Disclosure of your social security number/ITIN is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c)(2)(C)) authorize collection of your social security number/ITIN. Your social security number/ITIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure, certification or examination status by a licensing or examination entity which utilizes a national examination where licensure is reciprocal with the requesting state. **If you fail to list your social security number/ITIN, your application for initial or renewal license/certification will not be processed.** You will also be reported to the Franchise Tax Board, which may assess a $100 penalty against you. Questions regarding the Franchise Tax Board should be directed to (800) 852-5711.

ALERT: Effective July 1, 2012, the Board of Registered Nursing is required to deny an application for licensure and to suspend the license/certificate/registration of any applicant or licensee who has outstanding tax obligations due to the Franchise Tax Board (FTB) or the State Board of Equalization (BOE) and appears on either the FTB or BOE's certified lists of top 500 tax delinquencies over $100,000. (AB 1424, Perea, Chapter 455, Statutes of 2011).

IV. REPORTING PRIOR CONVICTIONS OR DISCIPLINE AGAINST LICENSES/CERTIFICATES

Applicants are required under law to report all misdemeanor and felony convictions. "Driving under the influence" convictions must be reported. Convictions must be reported even if they have been adjudicated, dismissed or expunged or even if a court ordered diversion program has been completed under the Penal Code or under Article 5 of the Vehicle Code. Also, all disciplinary action against an applicant's nurse practitioner, registered nurse, practical nurse, vocational nurse or other health care related license or certificate must be reported. Also any fine, infraction, or traffic violation over $1,000.00 must be reported.

Failure to report prior convictions or disciplinary action is considered falsification of application and is grounds for denial of licensure/certification or revocation of license/certificate.

When reporting prior convictions or disciplinary action, **applicants are required to provide a full written explanation of:** circumstances surrounding the arrest(s), conviction(s), and/or disciplinary action(s); the date of incident(s), conviction(s) or disciplinary action(s); specific violation(s) (cite section of law if convicted), court location or jurisdiction, sanctions or penalties imposed and completion dates. Provide **certified** copies of arrest and court documents and for disciplinary proceedings against any license as a RN or any health-care related license; include copies of state board determinations/decisions, citations and letters of reprimand.

NOTE: For drug and alcohol convictions include documents that indicate blood alcohol content (BAC) and sobriety date.

To make a determination in these cases, the Board considers the nature and severity of the offense, additional subsequent acts, recency of acts or crimes, compliance with court sanctions, and evidence of rehabilitation.

The burden of proof lies with the applicant to demonstrate acceptable documented evidence of rehabilitation. Examples of rehabilitation evidence include, but are not be limited to:

- Recent, dated letter from applicant describing the event and rehabilitative efforts or changes in life to prevent future problems or occurrences.
- Recent and signed letters of reference on official letterhead from employers, nursing instructors, health professionals, professional counselors, parole or probation officers, Support Group Facilitators or sponsors, or other individuals in positions of authority who are knowledgeable about your rehabilitation efforts.
- Letters from recognized recovery programs and/or counselors attesting to current sobriety and length of time of sobriety, if there is a history of alcohol or drug abuse.
- Submit copies of recent work evaluations.
- Proof of community work, schooling, self-improvement efforts.
- Court-issued certificate of rehabilitation or evidence of expungement, proof of compliance with criminal probation or parole, and orders of the court.

All of the above items should be mailed **directly** to the Board by the individual(s) or agency who is providing information about the applicant. Have these items sent to the Board of Registered Nursing, Licensing Unit – Advanced Practice Certification (NP), P.O. Box 944210, Sacramento, CA 94244-2100.

It is the responsibility of the applicant to provide sufficient rehabilitation evidence on a timely basis so that a certification determination can be made.

An applicant is also required to immediately report, in writing, to the Board any conviction(s) or disciplinary action(s) which occur between the date the application was filed and the date that a California Nurse Practitioner certificate is issued. Failure to report this information is grounds for denial of licensure or revocation of license/certificate.

NOTE: The application must be completed and signed by the applicant under the penalty of perjury.

V. TEMPORARY NURSE PRACTITIONER CERTIFICATE

The Nurse Practitioner certification applicant may apply for the Temporary Nurse Practitioner Certificate (TC/NP) only if the applicant does not possess a **permanent California RN license at the time of application**.

Eligibility for the TC/NP is based on:

- Possession of a temporary California RN license (TL).
- A completed Application for Licensure by Endorsement which includes written verification from a state where you hold an active and permanent RN license and results from the background check received from the California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). You also must request an official transcript be sent directly from your nursing program.
- A completed Application for Nurse Practitioner Certification which includes verification of completion of a Nurse Practitioner academic program, official transcript, and if applicable, verification of national certification as a Nurse Practitioner.

VI. BOARD ADDRESS & WEB SITE INFORMATION

Mailing Address: Advanced Practice Unit – NP Certification
Board of Registered Nursing
P.O. Box 944210
Sacramento, CA 94244-2100

Street Address for overnight or in-person delivery:

Advanced Practice Unit – NP Certification
Board of Registered Nursing
1747 N. Market Blvd., Suite 150
Sacramento, CA 95834-1924

Web Site: www.rn.ca.gov

VII. CALIFORNIA NURSING PRACTICE ACT

California statutes and regulations pertaining to Registered Nurses/Nurse Practitioners may be obtained by accessing the Board of Registered Nursing web site at www.rn.ca.gov

APPLICATION REQUIREMENTS FOR NURSE PRACTITIONER (NP) CERTIFICATION

METHOD ONE
(California Graduates Only)

Successful completion of a nurse practitioner program of study which conforms with the Board's educational standards set forth in the California Code of Regulations Section 1484.

Documentation submitted directly to the Board of Registered Nursing:

1. Completed **Application for Nurse Practitioner (NP) Certification** and applicable fee.
2. Completed **Verification of Nurse Practitioner Academic Program** form submitted by the nurse practitioner academic program. (Page 8)
3. Official transcripts for the completed nurse practitioner academic program submitted by the nurse practitioner academic program.

METHOD TWO

Certification by a national organization/association whose standards are equivalent to those set forth in the California Code of Regulations Section 1484.

Documentation submitted directly to the Board of Registered Nursing:

1. Completed **Application for Nurse Practitioner (NP) Certification** and applicable fee.
2. Completed **Verification of Nurse Practitioner Academic Program** form submitted by the nurse practitioner academic program. (Page 8)
3. Completed **Verification of Nurse Practitioner Certification by National Organization/Association** form submitted by the respective organization. (Page 9)
   (See page 5 for a list of National Organizations/Associations)
4. Official transcripts for the completed nurse practitioner academic program submitted by the nurse practitioner academic program.

METHOD THREE – EQUIVALENCY

A registered nurse who has not completed a nurse practitioner program of study which **meets** the Board of Registered Nursing's educational standards as specified in the California Code of Regulations Section 1484.

Documentation submitted directly to the Board of Registered Nursing:

1. Completed **Application for Nurse Practitioner (NP) Certification** and applicable fee.
2. Completed **Verification of Nurse Practitioner Academic Program** form submitted by the nurse practitioner academic program. (Page 8)
3. Completed **Verification of "Clinical Competency" as a Nurse Practitioner** form submitted by a **nurse practitioner**. (Page 10)
4. Completed **Verification of "Clinical Competency" as a Nurse Practitioner** form submitted by a **physician**. (Page 11)
5. Completed **Verification of "Clinical Experience" as a Nurse Practitioner** form submitted by the physician **and/or** nurse practitioner. (Page 12)
6. Official transcripts for the completed nurse practitioner academic program and/or academic program submitted by the applicable program.
7. Curriculum and course descriptions for the completed academic program for the period of time attended.

APPLICATION REQUIREMENTS FOR NURSE PRACTITIONER (NP) CERTIFICATION – (continued)

The national organizations/associations listed below have met the certification requirements that are equivalent to the Board's standards for nurse practitioner certification:

- **American Academy of Nurse Practitioners (AANP)**
  P. O. Box 12846, Austin, TX 78711
  (512) 442-4262
  www.aanp.org

- **American Nurses Association - American Nurses Credentialing Center (ANCC)**
  8515 Georgia Ave., Suite 400, Silver Spring, MD 20910-3402
  (800) 284-2378
  www.nursecredentialing.org

- **Pediatric Nursing Certification Board**
  800 S. Frederick Ave., Suite 204, Gaithersburg, MD 20877-4152
  (888) 641-2767
  www.pncb.org

- **National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC)**
  142 E. Ontario Street, Suite 1700, Chicago, IL 60611
  (312) 951-0207
  www.nccwebsite.org

- **American Association of Critical-Care Nurses (AACN)**
  101 Columbia, Aliso Viejo, CA 92656-4109
  (800) 899-2226
  www.aacn.org

PLEASE REFER QUESTIONS REGARDING THE NURSE PRACTITIONER APPLICATION PROCESS TO THE ADVANCED PRACTICE UNIT IN SACRAMENTO AT (916) 322-3350.

VIII. HONORABLY DISCHARGED MEMBERS OF THE U.S. ARMED FORCES RECEIVE EXPEDITED REVIEW

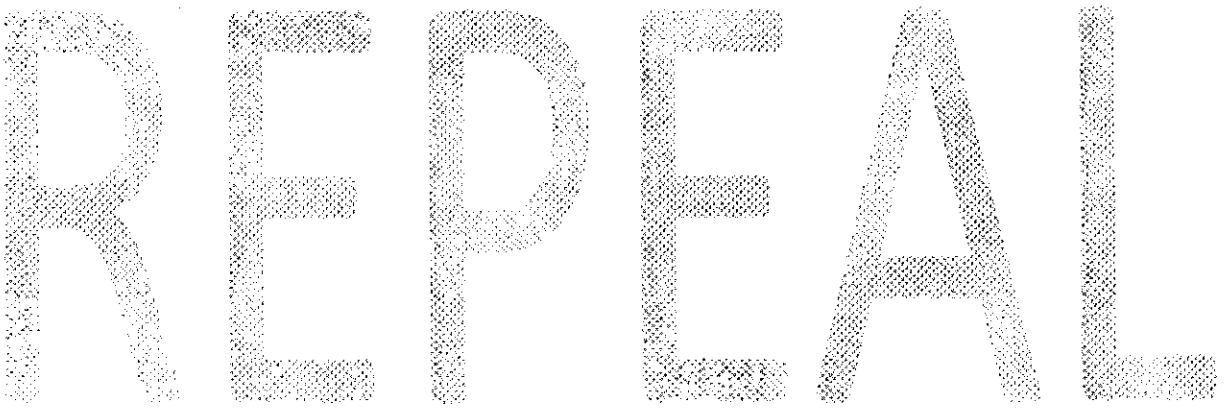
Notwithstanding any other law, on and after July 1, 2016, a board within the department shall expedite, and may assist, the initial licensure process for an applicant who supplies satisfactory evidence to the board that the applicant has served as an active duty member of the Armed Forces of the United States and was honorably discharged (Business and Professions Code section 115.4.).

If you would like to be considered for this expedited review and process, please provide the following documentation with your application:

1. **Report of Separation form.**

The report of separation form issued in most recent years is the **DD Form 214, Certificate of Release or Discharge from Active Duty**. Before January 1, 1950, several similar forms were used by the military services, including the WD AGO 53, WD AGO 55, WD AGO 53-55, NAVPERS 553, NAVMC 78PD and the NAVCG 553.

Information shown on the Report of Separation may include the service member's date and place of entry into active duty, date and place of release from active duty, last duty assignment and rank, military job specialty, military education, total creditable service, separation information, etc.



STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

APPLICATION FOR NURSE PRACTITIONER (NP) CERTIFICATION

APPLICATION FEE - $150.00

— MILITARY HONORABLE DISCHARGE - Check here If you served as an active duty
— member of the Armed Forces of the United States and were honorably discharged.

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:	E-MAIL ADDRESS:
( )	( )	

DATE OF BIRTH: *(Month/Day/Year)*	SOCIAL SECURITY NUMBER OR INDIVIDUAL TAXPAYER ID NUMBER:	PREVIOUS NAMES: *(Including Maiden)*	MOTHER'S MAIDEN NAME: *(Last Name 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:

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

RN 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

Area of Specialization: _____

TYPE OF NURSE PRACTITIONER ACADEMIC PROGRAM:

- ☐ CERTIFICATE
- ☐ MASTERS
- ☐ POST-MASTERS

Entrance Date: _____

Graduation/Completion Date: _____

NAME OF APPLICANT: _____

NURSE PRACTITIONER PROFESSIONAL CERTIFICATION *(If Applicable)*:

_____ Name of Organization/Association Area of Specialization: _____ Certification Number: _____	METHOD OF CERTIFICATION: ☐ EXAMINATION ☐ OTHER (Please Explain): 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: _____ Date Submitted: _____	☐ YES	☐ NO
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 reapply or file a petition for reinstatement of your California Nurse Practitioner certification.	☐ YES	☐ NO
Have you ever had disciplinary proceedings against **any** license as a RN or **any** health-care related license or certificate including revocation, suspension, probation, voluntary surrender, 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.	☐ YES	☐ NO
Have you ever been convicted of **any** offense other than minor traffic violations? If yes, explain fully as described in the applicant instructions. Convictions must be reported even if they have been adjudicated, dismissed or expunged or if a diversion program has been completed under the Penal Code or Article 5 of the Vehicle Code. Traffic violations 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 or verdicts of guilty. YOU MUST INCLUDE MISDEMEANOR AS WELL AS FELONY CONVICTIONS.	☐ YES	☐ NO

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 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 this 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 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.

Attach a recent 2"x2" passport type photograph.

Please tape on all four sides.

Head and shoulders only

_____ _____

SIGNATURE OF APPLICANT DATE

**** SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT**

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA (c)(2)(C) authorizes collection of your social security number. Your social security number 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 reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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 the official transcripts.

A. 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		SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:
TELEPHONE NUMBER: Home ( ) Alternate ( )	PREVIOUS NAMES: *(Including Maiden)*	MOTHER'S MAIDEN NAME: *(Last Name Only)*
E-MAIL ADDRESS:	CALIFORNIA RN LICENSE NUMBER: _____ EXPIRATION DATE: _____	
NAME OF ACADEMIC PROGRAM:		SPECIALTY:

SIGNATURE OF APPLICANT: _____ **DATE:** _____

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: _____

Entrance Date: _____ *(Month/Day/Year)*

Completion Date: _____ *(Month/Day/Year)*

Date Certificate/Degree Status Conferred: _____ *(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

(PRINT OR TYPE)

LAST NAME:	FIRST NAME:	MIDDLE NAME:
ADDRESS: Number & Street		DATE OF BIRTH: *(Month/Day/Year)*
City / State / Country / Postal/Zip Code		SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:
TELEPHONE NUMBER: Home ( ) Alternate ( )	PREVIOUS NAMES: *(Including Maiden)*	MOTHER'S MAIDEN NAME: *(Last Name Only)*
E-MAIL ADDRESS:	CALIFORNIA RN LICENSE NUMBER: _____ EXPIRATION DATE: _____	
NAME OF ACADEMIC PROGRAM:		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.

NAME OF CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION	TELEPHONE NUMBER: ( )		
ADDRESS: Number & Street	City	State	Postal/Zip Code
METHOD OF CERTIFICATION:	CERTIFICATE NUMBER:	ORIGINAL DATE OF CERTIFICATION:	
NURSE PRACTITIONER SPECIALTY AREA:			
CURRENT RENEWAL CYCLE DATES FOR CERTIFICATION/RECERTIFICATION: *(If not applicable, please explain)* 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:** _____

(OFFICIAL SEAL)

VERIFICATION OF "CLINICAL COMPETENCY" AS A NURSE PRACTITIONER

METHOD 3 - EQUIVALENCY

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

PRIMARY HEALTH CARE is that care which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease. *(California Code of Regulations Section 1480(b)).*

CLINICALLY COMPETENT means that one possesses and exercises that degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice. *(California Code of Regulations Section 1480(c))*. 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 health care.

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 health care.**
3. **Direct observations of clinical practice.**

A. TO BE COMPLETED BY APPLICANT

(PRINT OR TYPE)

LAST NAME:	FIRST NAME:	MIDDLE NAME:

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 EVALUATING "NURSE PRACTITIONER"

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.

LAST NAME:	FIRST NAME:	MIDDLE NAME:

ADDRESS OF AGENCY: Number & Street	City	State	Postal/Zip Code

TELEPHONE NUMBER:	SOCIAL SECURITY NUMBER:

RN LICENSE NUMBER: _____ EXPIRATION DATE: _____ NP CERTIFICATION NUMBER: _____	DATES EMPLOYED IN SPECIALTY AREA: From: _____ To: _____ PROFESSIONAL SPECIALTY: _____

METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY:	PERIOD OF CLINICAL EVALUATION: From: _____ (Month/Year) To: _____ (Month/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 health 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 health care is one of the requirements, which must be met in order to qualify to use the title "Nurse Practitioner" in California.

PRIMARY HEALTH CARE is that care which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease. *(California Code of Regulations Section 1480(b))*.

CLINICALLY COMPETENT means that one possesses and exercises that degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice. *(California Code of Regulations Section 1480(c))*. 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 health care.

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 health care.**
3. **Direct observations of clinical practice.**

A. TO BE COMPLETED BY APPLICANT

(PRINT OR TYPE)

LAST NAME:	FIRST NAME:	MIDDLE NAME:
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 EVALUATING "PHYSICIAN"

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.

LAST NAME:	FIRST NAME:	MIDDLE NAME:
ADDRESS OF AGENCY: Number & Street	City	State / Postal/Zip Code
TELEPHONE NUMBER:	**SOCIAL SECURITY NUMBER:**	
MD LICENSE NUMBER: _____ **EXPIRATION DATE:** _____	**DATES EMPLOYED IN SPECIALTY AREA:** **From:** _____ **To:** _____ **PROFESSIONAL SPECIALTY:** _____	
METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY:	**PERIOD OF CLINICAL EVALUATION:** **From:** _____ (Month/Year) **To:** _____ (Month/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 health 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 health care is required in order for him/her to use the title "Nurse Practitioner" in California.

PRIMARY HEALTH CARE is that care which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease. *(California Code of Regulations Section 1480(b)).*

CLINICALLY COMPETENT means that one possesses and exercises that degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice. *(California Code of Regulations Section 1480(c))*. 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 health care.

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 health care.**
3. **Direct observations of clinical practice.**

A. TO BE COMPLETED BY APPLICANT

(PRINT OR TYPE)

LAST NAME:	FIRST NAME:	MIDDLE NAME:
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.

NAME OF AGENCY:			
ADDRESS OF AGENCY: **Number & Street**	**City**	**State**	**Postal/Zip Code**

NAME OF APPLICANT'S SUPERVISOR:	**SUPERVISOR'S TELEPHONE NUMBER:**
SUPERVISOR'S TITLE: _____ **LICENSE NUMBER:** _____ **EXPIRATION DATE:** _____	**DATES OF SUPERVISOR'S EMPLOYMENT:** **From:** _____ **To:** _____ **SPECIALTY AREA:** _____

DATES OF SUPERVISED CLINICAL EXPERIENCE:	**NUMBER OF HOURS:**	**CLICICAL SPECIALITY:**
From: _____ **To:** _____		
From: _____ **To:** _____		
From: _____ **To:** _____		

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 health care.

SIGNATURE OF SUPERVISOR: _____ **DATE:** _____

APPLICATION FOR TEMPORARY NURSE PRACTITIONER (NP) CERTIFICATE

INSTRUCTIONS:

1. The application fee for the Temporary Nurse Practitioner Certificate (TC/NP) is **$30.00.**
2. The TC/NP will not be issued until the **California RN Endorsement Application** and the **Application for Nurse Practitioner Certification** are 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 address.
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	SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:

TELEPHONE NUMBER: Home ( ) Alternate ( )	PREVIOUS NAMES: *(Including Maiden)*	MOTHER'S MAIDEN NAME: *(Last Name Only)*

E-MAIL ADDRESS:	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:** _____

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 OFFICER**
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 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 SOCIAL SECURITY NUMBER 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 94-455 (42 USCA 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR SOCIAL SECURITY NUMBER. IF YOU FAIL TO DISCLOSE YOUR SOCIAL SECURITY NUMBER, 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 SOCIAL SECURITY NUMBER 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 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 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.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

INSTRUCTIONS FOR APPLYING FOR A NURSE PRACTITIONER FURNISHING NUMBER

Section 2836.3 of the Business and Professions Code requires that the Nurse Practitioner who wishes to furnish drugs and/or devices pursuant to Section 2836.1 have a California Board of Registered Nursing issued furnishing number. The number is renewable at the time of the applicant's Registered Nursing (RN) license renewal. To be eligible for the furnishing number, the California Board of Registered Nursing certified Nurse Practitioner must have completed a California Board of Registered Nursing approved advanced pharmacology course. The advanced pharmacology course must be completed at any nationally accredited master's or post-master's level academic Nurse Practitioner program. Continuing Education course(s) are not acceptable to meet the Nurse Practitioner Furnishing Number advanced pharmacology course requirement.

APPLICATION PROCESS

For applicants who completed a California Board of Registered Nursing approved Nurse Practitioner (NP) Advanced Pharmacology Course, please provide the following:

- Nurse Practitioner Furnishing Number Application form completed by the applicant and $50.00 application fee.
- Advanced Pharmacology Course Verification form completed by the director of the Nurse Practitioner program.

For applicants who completed a Nurse Practitioner (NP) Advanced Pharmacology course more than five (5) years preceding the date of submitting the application to the California Board of Registered Nursing, in addition to the items noted above, you must also provide the following:

- A verification(s) of employment history which contains a minimum of five (5) years experience working as a Nurse Practitioner and prescribing/furnishing medication.
- A copy of your state license/certificate that allows you to prescribe/furnish medication as a Nurse Practitioner.
- A copy of your Drug Enforcement Agency (DEA) pocket identification card.
- A copy of that State's rules/regulations regarding prescriptive/furnishing authority for Nurse Practitioners.
- If applicable, a copy of the procedures/protocols/collaborative/practice agreement set in place by the supervising physician that allowed the Nurse Practitioner to use their prescriptive/furnishing authority in the state where they are licensed/certified.

Falsification of information on the application is a violation of the Nursing Practice Act and may result in not only denial of the issuance of the furnishing number, but also in Board disciplinary action against the applicant's registered nursing license.

HONORABLY DISCHARGED MEMBERS OF THE U.S. ARMED FORCES RECEIVE EXPEDITED REVIEW

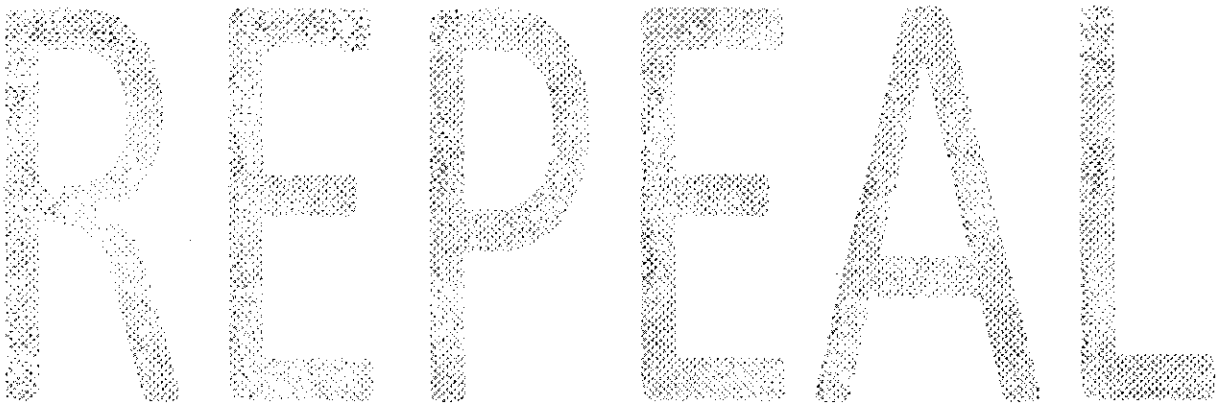
Notwithstanding any other law, on and after July 1, 2016, a board within the department shall expedite, and may assist, the initial licensure process for an applicant who supplies satisfactory evidence to the board that the applicant has served as an active duty member of the Armed Forces of the United States and was honorably discharged (Business and Professions Code section 115.4.).

If you would like to be considered for this expedited review and process, please provide the following documentation with your application:

1. **Report of Separation form.**

The report of separation form issued in most recent years is the **DD Form 214, Certificate of Release or Discharge from Active Duty**. Before January 1, 1950, several similar forms were used by the military services, including the WD AGO 53, WD AGO 55, WD AGO 53-55, NAVPERS 553, NAVMC 78PD and the NAVCG 553.

Information shown on the Report of Separation may include the service member's date and place of entry into active duty, date and place of release from active duty, last duty assignment and rank, military job specialty, military education, total creditable service, separation information, etc.



STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

NURSE PRACTITIONER FURNISHING NUMBER APPLICATION

FEE - $50.00

— MILITARY HONORABLE DISCHARGE - Check here if you served as an active duty
— member of the Armed Forces of the United States and were honorably discharged.

PERSONAL DATA *(PRINT OR TYPE)*

LAST NAME:	FIRST NAME:	MIDDLE NAME:
ADDRESS: Number & Street		DATE OF BIRTH: *(Month/Day/Year)*
City / State / Country / Zip Code		SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:**
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 / NAME OF ACADEMIC COURSE:	COURSE TITLE:	COMPLETION DATE:	# QTR/SEM UNITS:
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:** _____

**** SOCIAL SECURITY NUMBER/ITIN DISCLOSURE STATEMENT**

Disclosure of your social security number/ITIN is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA (c)(2)(C) authorizes collection of your social security number/ITIN. Your 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 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 reciprocal with the requesting state. If you fail to disclose your social security number/ITIN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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

(PRINT OR TYPE)

LAST NAME:	FIRST NAME:			MIDDLE NAME:
ADDRESS: Number & Street				DATE OF BIRTH: *(Month/Day/Year)*
City	State	Country	Zip Code	SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:
TELEPHONE NUMBER: Home ( ) Alternate ( )	PREVIOUS NAMES: *(Including Maiden)*			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. 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:**
ADDRESS: Number & Street	**City**	**State**	**Zip Code**

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:** _____

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)

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 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 Health and Safety Code section 11000 for NPs.
- 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 11056 for CNMs.
- The Pharmacy Rules and Regulations for NPs and CNMs, Health & Safety Codes and OBRA 1990 Section 483.40, Federal Register.

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 implement 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. Includes knowledge of Pharmacy rules and regulations, Health & Safety Code and Federal Register.
7. Examines 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.
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 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 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 correct 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, antiarrhythmics, antihypertensives contraceptives, etc. used in specific treatment regimens.
- Uses data obtained during a client's H&P to identify appropriate drug choice/s and herbs, vitamins, minerals, and trace elements regimen/s, and recognizes the role of herbal and natural remedies in the treatment of health and disease states.
- Based upon the principles of pharmacokinetics and pharmacodynamics, identifies the indications, rationale, and mechanism of action for drugs 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 efficacy of drug/s evaluates the response and compliance of the client to the drugs/devices and provides interventions for side effects, and manages adverse events that may occur.
- Identifies drugs with narrow therapeutic range.
- Identifies appropriate methods to write and transmit prescriptions.
- Furnishes drugs pursuant to legal requirements, standardized procedures, ethical standards, and in compliance with health and safety codes.
- Identifies resources for drug information and uses the resources to maintain clinical competency for furnishing.
- Describes the essential components of client education re: medications including: name of medication/s frequency/time of doses, 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 base upon client's symptomatology, health status, and lifestyle.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 OFFICER**
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 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 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 94-455 (42 USCA 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR SOCIAL SECURITY NUMBER/ITIN. IF YOU FAIL TO DISCLOSE YOUR 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 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 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 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.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

APPLICATION FOR NURSE PRACTITIONER (NP) CERTIFICATION

APPLICATION FEE - $500.00

☐ MILITARY HONORABLE DISCHARGE - Check here if you served as an active duty member of the Armed Forces of the United States and were honorably discharged.

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:	E-MAIL ADDRESS:
( )	( )	

DATE OF BIRTH: *(Month/Day/Year)*	U.S. SOCIAL SECURITY NUMBER OR INDIVIDUAL TAXPAYER ID NUMBER:	PREVIOUS NAMES: *(Including Maiden)*	MOTHER'S MAIDEN NAME: *(Last Name 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:

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

RN 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

Area of Specialization: _____

TYPE OF NURSE PRACTITIONER ACADEMIC PROGRAM:

- ☐ CERTIFICATE
- ☐ MASTERS
- ☐ POST-MASTERS

Entrance Date: _____

Graduation/Completion Date: _____

NAME OF APPLICANT: _____

NURSE PRACTITIONER PROFESSIONAL CERTIFICATION *(If Applicable)*:

_____ **Name of Organization/Association**	**METHOD OF CERTIFICATION:** ☐ **EXAMINATION** ☐ **OTHER (Please Explain):**
Area of Specialization: _____	**Original Date of Certification:** _____
Certification Number: _____	**Current Recertification Cycle Dates:** _____

BACKGROUND INFORMATION

Have you **applied** for a Nurse Practitioner certificate in California? If yes, name on previous application: _____ Date Submitted: _____	☐ YES	☐ NO
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 reapply or file a petition for reinstatement of your California Nurse Practitioner certification.	☐ YES	☐ NO
Have you ever had disciplinary proceedings against **any** license as a RN or **any** health-care related license or certificate including revocation, suspension, probation, voluntary surrender, 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.	☐ YES	☐ NO
Have you ever been convicted of **any** offense other than minor traffic violations? If yes, explain fully as described in the applicant instructions. Convictions must be reported even if they have been adjudicated, dismissed or expunged or if a diversion program has been completed. Traffic violations 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 or verdicts of guilty. YOU MUST INCLUDE MISDEMEANOR AS WELL AS FELONY CONVICTIONS.	☐ YES	☐ NO

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 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 this 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 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.

Attach a recent 2"x2" passport type photograph.

Please tape on all four sides.

Head and shoulders only

_____ _____

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)(2)(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 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 reciprocal with the requesting state. If you fail to disclose your U.S. Social Security Number/ITIN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY · GOVERNOR EDMUND G. BROWN JR

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 the official transcripts.

A. 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 ( )	**PREVIOUS NAMES:** *(Including Maiden)*			**MOTHER'S MAIDEN NAME:** *(Last Name Only)*
E-MAIL ADDRESS:				**CALIFORNIA RN LICENSE NUMBER:** _____ **EXPIRATION DATE:** _____
NAME OF ACADEMIC PROGRAM:				**SPECIALTY:**

SIGNATURE OF APPLICANT: _____ **DATE:** _____

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: _____

Entrance Date: _____ *(Month/Day/Year)*

Completion Date: _____ *(Month/Day/Year)*

Date Certificate/Degree Status Conferred: _____ *(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: _____ _____ **TITLE:** _____
(DATE)

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY · GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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

(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 ( )	PREVIOUS NAMES: *(Including Maiden)*	MOTHER'S MAIDEN NAME: *(Last Name Only)*

E-MAIL ADDRESS:	CALIFORNIA RN LICENSE NUMBER: _____ EXPIRATION DATE: _____

NAME OF ACADEMIC PROGRAM:	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.

NAME OF CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION	TELEPHONE NUMBER: ( )

ADDRESS: Number & Street	City	State	Postal/Zip Code

METHOD OF CERTIFICATION:	CERTIFICATE NUMBER:	ORIGINAL DATE OF CERTIFICATION:

NURSE PRACTITIONER SPECIALTY AREA:

CURRENT RENEWAL CYCLE DATES FOR CERTIFICATION/RECERTIFICATION:
(If not applicable, please explain)

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: _____ _____ **TITLE:** _____
(DATE)

(OFFICIAL SEAL)

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY · GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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, patient education and the diagnoses and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(b)).*

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, 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 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

(PRINT OR TYPE)

LAST NAME:	**FIRST NAME:**	**MIDDLE NAME:**
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 EVALUATING "NURSE PRACTITIONER"

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.

LAST NAME:	**FIRST NAME:**	**MIDDLE NAME:**	
ADDRESS OF AGENCY: Number & Street	**City**	**State**	**Postal/Zip Code**
TELEPHONE NUMBER:	**U.S. SOCIAL SECURITY NUMBER:**		
RN LICENSE NUMBER: _____ **EXPIRATION DATE:** _____ **NP CERTIFICATION NUMBER:** _____	**DATES EMPLOYED IN SPECIALTY AREA:** **From:** _____ **To:** _____ **PROFESSIONAL SPECIALTY:** _____		
METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY:	**PERIOD OF CLINICAL EVALUATION:** **From:** _____ **To:** _____ (Month/Year) (Month/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:** _____

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY · GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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, patient education and the diagnoses and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(b)).*

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, 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 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

(PRINT OR TYPE)

LAST NAME:	FIRST NAME:	MIDDLE NAME:
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 EVALUATING "PHYSICIAN"

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.

LAST NAME:	FIRST NAME:	MIDDLE NAME:

ADDRESS OF AGENCY: Number & Street	City	State	Postal/Zip Code

TELEPHONE NUMBER:	U.S. SOCIAL SECURITY NUMBER:
MD LICENSE NUMBER: _____ EXPIRATION DATE: _____	DATES EMPLOYED IN SPECIALTY AREA: From: _____ To: _____ PROFESSIONAL SPECIALTY: _____
METHOD(S) UTILIZED TO EVALUATE APPLICANT'S CLINICAL COMPETENCY:	PERIOD OF CLINICAL EVALUATION: From: _____ (Month/Year) To: _____ (Month/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:** _____

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY · GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 diagnoses and treatment of acute and chronic illnesses in a variety of practice settings. *(California Code of Regulations Section 1480(b)).*

CLINICALLY COMPETENT means the individual possesses and exercises the degree of learning, 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 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

(PRINT OR TYPE)

LAST NAME:	**FIRST NAME:**	**MIDDLE NAME:**
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.

NAME OF AGENCY:			
ADDRESS OF AGENCY: **Number & Street**	**City**	**State**	**Postal/Zip Code**
NAME OF APPLICANT'S SUPERVISOR:	**SUPERVISOR'S TELEPHONE NUMBER:**		
SUPERVISOR'S TITLE: _____ **LICENSE NUMBER:** _____ **EXPIRATION DATE:** _____	**DATES OF SUPERVISOR'S EMPLOYMENT:** **From:** _____ **To:** _____ **SPECIALTY AREA:** _____		
DATES OF SUPERVISED CLINICAL EXPERIENCE: **From:** _____ **To:** _____ **From:** _____ **To:** _____ **From:** _____ **To:** _____	**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:*** _____

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 OFFICER**
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 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 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 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.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 a third party address.
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 ( )	PREVIOUS NAMES: *(Including Maiden)*	MOTHER'S MAIDEN NAME: *(Last Name Only)*
E-MAIL ADDRESS:	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:** _____

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 OFFICER**
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 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 94-455 (42 USC 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 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.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

NURSE PRACTITIONER FURNISHING NUMBER APPLICATION

APPLICATION FEE - $400.00

☐ **MILITARY HONORABLE DISCHARGE** - Check here if you served as an active duty member of the Armed Forces of the United States and were honorably discharged.

PERSONAL DATA *(PRINT OR TYPE)*

LAST NAME:	FIRST NAME:	MIDDLE NAME:
ADDRESS: Number & Street		DATE OF BIRTH: *(Month/Day/Year)*
City / State / Country / Zip Code		U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:**
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 NAME OF ACADEMIC COURSE:	COURSE TITLE:	COMPLETION DATE:	# QTR/SEM UNITS:
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)(2)(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 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 reciprocal with the requesting state. If you fail to disclose your U.S. Social Security Number/ITIN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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

(PRINT OR TYPE)

LAST NAME:	FIRST NAME:	MIDDLE NAME:
ADDRESS: Number & Street		DATE OF BIRTH: *(Month/Day/Year)*
City / State / Country / Zip Code		U.S. SOCIAL SECURITY NUMBER or INDIVIDUAL TAXPAYER ID NUMBER:
TELEPHONE NUMBER: Home ( ) Alternate ( )	PREVIOUS NAMES: *(Including Maiden)*	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. 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:
ADDRESS: Number & Street	City	State	Zip Code

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:** _____

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: _____ _____ *(DATE)* **TITLE:** _____

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 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, Uniform Controlled Substances Act, Sections 11000-11651, 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, 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 implement 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/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 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 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 correct 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, antiarrhythmics, antihypertensives contraceptives, 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, and trace elements regimen/s, and recognizes the role of herbal and natural remedies in the treatment of health and disease states.
- Based upon the principles of pharmacokinetics and pharmacodynamics, identifies the indications, rationale, and mechanism of action for drugs 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 efficacy of drug/s evaluates the response and compliance of the client to the drugs/devices and provides interventions for side effects, and manages adverse events that may occur.
- Identifies drugs with narrow therapeutic range.
- Identifies appropriate methods to write and transmit prescriptions.
- Furnishes drugs pursuant to legal requirements, standardized procedures, ethical standards, and in compliance with health and safety codes.
- Identifies resources for drug information and uses the resources to maintain clinical competency for furnishing.
- Describes the essential components of client education re: medications including: name of medication/s frequency/time of doses, 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 base upon client's symptomatology, health status and lifestyle.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

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 OFFICER**
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 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 94-455 (42 USC 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 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.