

# Nursing Licensure by Endorsement Application



**Board of Nursing**  
**P.O. Box 6330**  
**Tallahassee, FL 32314-6330**  
**Website: [www.floridasnursing.gov](http://www.floridasnursing.gov)**  
**Email: [Mqa.Nursingappstatus@flhealth.gov](mailto:Mqa.Nursingappstatus@flhealth.gov)**  
**Phone: (850) 245-4125**  
**Fax: (850) 617-6460**





**Are you an active duty member of the United States Armed Services?**

**Are you a veteran of the United States Armed Services?**

**Are you the spouse of a veteran of the United States Armed Services?**

**Are you the spouse of an active member of the United States Armed Services?**

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

<http://www.flhealthsource.gov/valor>



## Nurse Licensure Compact State Information

Florida is a member of the Nurse Licensure Compact (NLC). The NLC allows a registered nurse or licensed practical nurse licensed in a Compact State to practice across state lines in another Compact State without having to obtain a license in the other state unless the nurse moves and declares the new Compact State as their new primary state of residence. It is important to understand that the NLC requires nurses to adhere to the nursing practice laws and rules of the state in which they practice under their Compact license. The Compact does not include Advanced Practice Registered Nurses. If a nurse moves from one state to another and establishes residency, the nurse must apply for licensure in that state. Visit the National Council of State Boards of Nursing (NCSBN) website <https://www.ncsbn.org/nurse-licensure-compact.htm> for a list of states that have implemented the Compact.

### Who is Eligible to Apply for Licensure by Endorsement?

**Section (s.) 464.009, Florida Statutes (F.S.), allows for three different methods to qualify for licensure by endorsement.**

- (1) The department shall issue the appropriate license by endorsement to practice professional or practical nursing to an applicant who, upon applying to the department..., demonstrates to the board that he or she:

**Have you taken the State Board Test Pool Exam (SBTPE) or National Council Licensure Examination (NCLEX)? Do you have an active license in another United States (U.S.) state or territory?**

- (a) Holds a valid license to practice professional or practical nursing in another state or territory of the United States, provided that, when the applicant secured his or her original license, the requirements for licensure were substantially equivalent to or more stringent than those existing in Florida at the time;

**Have you taken the SBTPE or NCLEX, but do not have an active license in another U.S. state or territory?**

- (b) Meets the qualifications for licensure in s. 464.008, F.S., and has successfully completed a state, regional, or national examination which is substantially equivalent to or more stringent than the examination given by the department; or

**Are you an applicant who has not taken the SBTPE or NCLEX? Have you practiced as a nurse in another U.S. state or territory for 24 of the last 36 months without any disciplinary action? Applicants with any criminal history do not qualify for this method of licensure. (This method qualifies for single-state licensure only.)**

- (c) Has actively practiced nursing in another state, jurisdiction, or territory of the United States for 2 of the preceding 3 years without having his or her license acted against by the licensing authority of any jurisdiction. Applicants who become licensed pursuant to this paragraph must complete within 6 months of licensure a Florida laws and rules course that is approved by the board. Once the department has received the results of the national criminal history check and has determined that the applicant has no criminal history, the appropriate license by endorsement shall be issued to the applicant.
- Canadian Registered Nurses who took the Canadian Nurse Association Testing Service (CNATS) Examination after August 8, 1995 must take the NCLEX unless licensed in another U.S. state or territory. If test scores are in an acceptable range, Canadian Registered Nurse applicants who took the CNATS prior to August 8, 1995 may be eligible for endorsement. Unless licensed in another U.S. state or territory, or have taken the NCLEX, Canadian Licensed Practical Nurses are required to apply by examination.



# Nursing Licensure by Endorsement Application

Board of Nursing  
P.O. Box 6330  
Tallahassee, FL 32314-6330  
Fax: 850-617-6460  
Email: mqa.nursingappstatus@flhealth.gov

Do Not Write in this Space  
For Revenue Receiving Only

### Select application type:

- Registered Nurse (RN) 1701- \$110.00
- Licensed Practical Nurse (LPN) 1702- \$110.00

### Total fee of \$110.00 includes the following:

Processing Fee	\$50.00
Initial Licensure Fee	\$50.00
Student Loan Forgiveness Fund	\$5.00
Unlicensed Activity Fee	\$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a \$60.00 (Initial Licensure Fee, Student Loan Forgiveness Fund, and Unlicensed Activity Fee) refund. Fees are refundable for up to three years from the date of receipt.

## 1. PERSONAL INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

Street/P.O. Box Apt. No. City  
State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

Street Apt. No. City  
State ZIP Country Work/Cell Telephone

### EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: Male	Race: Native Hawaiian or Pacific Islander	Hispanic or Latino	White
Female	American Indian or Alaska Native	Black or African American	Asian
	Two or More Races		

Email Notification: To be notified of the status of your application by email check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: \_\_\_\_\_

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

## 2. SOCIAL SECURITY DISCLOSURE

**This information is exempt from public records disclosure.**

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, s. 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

**Last Name:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Middle Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Social Security Information-** \* Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at [www.ssa.gov](http://www.ssa.gov) or by calling 1-800-772-1213.

***You may apply for licensure before obtaining a U.S. Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.***

**Board of Nursing**  
4052 Bald Cypress Way Bin C-02  
Tallahassee, FL 32399-3252

Name: \_\_\_\_\_

### 3. NURSE LICENSURE COMPACT (NLC)

#### Requirements that must be met to qualify for a multistate license from Florida:

Florida must be the Primary State of Residence*
Must have passed the NCLEX or the SBTPE
Florida's requirements for initial licensure must be met
The status of <b>all</b> nursing licenses (CNA, LPN, RN, and APRN) must be clear and unencumbered in all jurisdictions**
Must not have <b>any</b> misdemeanor conviction*** related to the practice of nursing, <b>regardless of adjudication</b>
Must not have <b>any</b> felony conviction***, <b>regardless of adjudication</b>
Must not be enrolled with the Intervention Project for Nurses (IPN) or any other treatment program for impaired practitioners
Must have a U.S. Social Security number
Must have completed an LPN or RN program, PNEQ <b>does not</b> qualify
<b>Applicants Educated Outside the U.S. or NCSBN Jurisdictions <u>Only</u></b>
Education must be evaluated by an independent credentials review agency
Education completed in a language other than English will require an English competency examination

#### Terminology:

**\*Primary state of residence** is defined by the Compact as the "person's declared fixed permanent and principal home for legal purposes; domicile."

**\*\*Encumbrance** means "revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing, imposed by a licensing board."

**\*\*\*Conviction** is defined as being "convicted or found guilty, or has entered into an agreed disposition other than a disposition that results in nolle prosequi, for an offense under applicable state or federal criminal law."

#### **Proof of primary residence may include but is not limited to:**

Driver license with a home address
Voter registration card displaying a home address
Federal income tax return declaring the primary state of residence
W2 from U.S. Government or any bureau, division, or agency thereof indicating the declared state of residence

A. Do you declare Florida to be your primary state of residence for multistate licensure and are you providing a Florida address? If you **only** want a single state license, select "No."      Yes      No

If you **do not have a current Florida mailing address, and wish to have a multistate license, you must provide** one of the documents listed above. If Florida is not your primary state of residence, you are **not eligible** for a Florida multistate license and your application will be processed for a single state license.

B. Do you hold an active NLC multistate license in another state?      Yes      No

**A nurse may only hold one multistate license.** If your declared primary state of residence is another Compact state and you are not changing your primary residence to Florida, you are **not eligible** for a multistate license in Florida and should **not submit this application**, as your NLC license allows you to practice in Florida.

Name: \_\_\_\_\_

#### 4. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

\_\_\_\_\_

B. If you have previously been licensed, what name did you use when you were first licensed?

\_\_\_\_\_

C. Have you ever applied for nursing licensure in Florida?      Yes      No

If “Yes,” complete the following:

Application Method		License Type		Date (MM/DD/YYYY)
Examination	Endorsement	LPN	RN	
Examination	Endorsement	LPN	RN	

D. Have you ever held a nursing license in Florida?      Yes      No

If “Yes,” complete the following:

License Type		Date (MM/DD/YYYY)
LPN	RN	
LPN	RN	

E. Do you hold, or have you ever held a license to practice nursing or any other health-related license(s)?  
Yes      No

F. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

**The board requires verification** of licensure from your original state of licensure (exam state) and from a state where you have a current active license. Only one verification is required if your original state is current and active. **Office staff will attempt to complete verifications online.** If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification.

#### 5. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?      Yes      No

If you respond “Yes,” your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Name: \_\_\_\_\_

## 6. EDUCATION HISTORY

A. List the nursing school(s) you attended.

<b>School Name:</b>		<b>School Address:</b> (Street, City, State, ZIP, Country)				
<b>Graduation Date (MM/DD/YYYY) :</b>		<b>Degree Awarded:</b>	<b>Diploma</b>	<b>LPN</b>	<b>ADN</b>	<b>BSN</b>

<b>School Name:</b>		<b>School Address:</b> (Street, City, State, ZIP, Country)				
<b>Graduation Date (MM/DD/YYYY) :</b>		<b>Degree Awarded:</b>	<b>Diploma</b>	<b>LPN</b>	<b>ADN</b>	<b>BSN</b>

B. What name(s) did you use when you received your nursing education?

**Only** applicants applying for a **multistate license** who were **educated outside the U.S., or Graduates from U.S. Territories** whose regulatory nursing board is **not a member of the National Council of State Boards of Nursing (NCSBN)** are required to have a **full education credentials review** by a Florida board-approved credentialing agency, or provide proof from your original licensing jurisdiction that an approved evaluation has been completed.

An original copy of the credentials report must be sent electronically to the board directly from the agency. The board does not accept paper copies. Applicants are responsible for paying all fees the agency charges for these services.

**Credentials reports received from a credentialing agency not listed below will not be accepted.**

### Board-Approved Education Evaluation Providers

**Ashland Educational Services  
Foreign Credentials Evaluation Agency**  
15192 S.W. 137 Street, Suite 10  
Miami, FL 33196, USA  
Phone: (786) 457-4608  
Email: Admin@AshlandEducationalServices.com  
Web: <http://ashlandeducationalservices.com/>

**Educational Records Evaluation Service, Inc.**  
2480 Hilborn Road, Suite 106  
Fairfield, CA 94534, USA  
Phone: (707) 759-2866  
Email: edu@eres.com  
Web: [www.eres.com](http://www.eres.com)

**Josef Silny & Associates, Inc.  
International Education Consultants**  
7101 S.W. 102 Avenue  
Miami, FL 33173, USA  
Phone: (305) 273-1338  
Fax: (305) 273-1338  
Email: info@jsilny.org  
Web: [www.jsilny.org](http://www.jsilny.org)

**Commission on Graduates of  
Foreign Nursing Schools**  
3600 Market Street, Suite 400  
Philadelphia, PA 19104-2641, USA  
Applicant Inquiries: (215) 349-8767  
Customer Service Fax: (215) 622-0425  
Automated Phone System (to check status):  
(215) 599-6200  
Email: info@cgfns.org  
Web: [www.cgfns.org](http://www.cgfns.org)



Name: \_\_\_\_\_

**Only** Applicants applying for a **multistate license** who were **educated outside the U.S., or Graduates from U.S. Territories** whose regulatory nursing board is **not a member of the NCSBN** are required to provide proof of English competency.

### Approved English Competency Exams

#### IELTS Cambridge/IELTS International

100 East Corson Street, Suite 200  
Pasadena, CA 91103, USA  
Phone: (626) 564-2954  
Fax: (626) 564-2981  
Email: [ielts@ceii.org](mailto:ielts@ceii.org)  
Web: [www.ielts.org](http://www.ielts.org)

#### Michigan Language Assessment

Argus 1 Building  
535 West William Street, Suite 310  
Ann Arbor, MI 48104-4978, USA  
Phone: (734) 615-9629  
Fax: (734) 763-0369  
Web: <https://michiganassessment.org/michigan-tests/met/>

#### Occupational English Test

(OET)  
Post Office Box 16136  
Collins St. West VIC 8007  
Australia  
Web: <https://www.occupationalenglishtest.org/>

#### TOEFL Services

Educational Testing Service  
Post Office Box 6151  
Princeton, NJ 08541-6151, USA  
Phone: (609) 771-7100  
Fax: (609) 734-1560  
Email: [Toefl@ets.org](mailto:Toefl@ets.org)  
Web: [www.ets.org](http://www.ets.org)

Other methods of providing proof of English competency can be found at:  
<https://floridasnursing.gov/forms/licensure-info-edu-outside-us.pdf>

**Applicants with questions regarding Visas or work permits should contact:**

#### Bureau of Immigration and Customs Enforcement

4255 "I" Street N.W.  
Washington D.C. 20536, USA  
Phone: (800) 375-5283  
Web: [www.uscis.gov/portal/site/uscis](http://www.uscis.gov/portal/site/uscis)

**For Visa Screenings contact:**

#### Commission on Graduates of Foreign Nursing Schools (CGFNS)

3600 Market Street  
Philadelphia, PA 19104, USA  
Phone: (215) 349-8767  
Web: [www.cgfns.org](http://www.cgfns.org)

Name: \_\_\_\_\_

**This information is exempt from public records disclosure**

**7. EXAMINATION HISTORY**

Have you ever taken an examination for RN or LPN licensure?    Yes            No

If “Yes,” complete the following:

Examination		State/Country	Date (MM/YYYY)	Result	
LPN	RN			Pass	Fail
LPN	RN			Pass	Fail
LPN	RN			Pass	Fail
LPN	RN			Pass	Fail

Those who have not taken and passed the NCLEX or SBTPE are not eligible for multistate licensure and will be issued a single state license upon approval of their application.

**This information is exempt from public records disclosure**

**8. HEALTH HISTORY**

**If you fail to disclose the information requested in this section, your application may be denied.**

**Physical and Mental Health Disorders Impacting Ability to Practice**

- A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice?      Yes      No
- B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice?      Yes      No

**Substance-Related Disorders Impacting Ability to Practice**

- C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice?      Yes      No
- D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse?      Yes      No
- E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse?      Yes      No

**If a “Yes” response was provided to any of the questions in this section, provide the following documents directly to the board office:**

**A letter from a Licensed Health Care Practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

**A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

**For Multistate Applicants ONLY:**

Are you a current participant in an alternative to discipline program (i.e. Intervention Project for Nurses (IPN))?

Yes      No

Name: \_\_\_\_\_

## 9. DISCIPLINE HISTORY

- A. Have you ever been denied or is there now any proceeding to deny your application for any health care license to practice in Florida or any other state, jurisdiction, or country?      Yes      No
- B. Have you ever had any disciplinary action taken against your license to practice any health care related profession by the licensing authority in Florida or in any other state, jurisdiction, or country?      Yes      No
- C. Have you ever surrendered a license to practice any health care related profession in Florida or any other state, jurisdiction, or country while any such disciplinary charges were pending against you?      Yes      No
- D. Do you have any disciplinary action pending against you?      Yes      No

**If you responded “Yes” any to questions in this section, complete the following:**

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y   N
				Y   N
				Y   N

**If you responded “Yes” to any questions in this section, you must provide the following:**

**A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

Three current (*written in the last year*) professional **Letters of Recommendation**.

## 10. CRIMINAL HISTORY

- A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.      Yes      No

- B. Have you ever had any records sealed pursuant to s. 943.059, F.S., or other state’s applicable statute?  
Yes      No

**If you responded “Yes” in this section, complete the following:**

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y   N
				Y   N
				Y   N

**If you responded “Yes” in this section, you must provide the following:**

**Self-Explanation**, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

**Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

**Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Three current (*written within the last year*) professional **Letters of Recommendation**.

Name: \_\_\_\_\_

## 11. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

**IMPORTANT NOTICE:** Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction?      Yes      No

**If you responded “No” to the question above, skip to question 2.**

- a. If “Yes” to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation?      Yes      No
- b. If “Yes” to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation? (This question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.).      Yes      No
- c. If “Yes” to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?      Yes      No
- d. If “Yes” to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If “Yes” provide supporting documentation).  
Yes      No
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?      Yes      No

**If you responded “No” to the question above, skip to question 3.**

- a. If “Yes” to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?      Yes      No
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.?  
Yes      No

**If you responded “No” to the question above, skip to question 4.**

- a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?      Yes      No
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?      Yes      No

**If you responded “No” to the question above, skip to question 5.**

- a. Have you been in good standing with a state Medicaid program for the most recent five years?  
Yes      No
- b. Did termination occur at least 20 years before the date of this application?      Yes      No

Name: \_\_\_\_\_

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)?      Yes      No
- a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan?      Yes      No
- b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE?      Yes      No

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

**Supporting documentation** including court dispositions or agency orders where applicable.

**Documentation for sections 8 and 9 must be sent to the board office at [MQA.Nursing@flhealth.gov](mailto:MQA.Nursing@flhealth.gov) or mailed to:**

**Board of Nursing**  
4052 Bald Cypress Way Bin C-02  
Tallahassee, FL 32399-3252

**Documentation for sections 10 and 11 must be sent to the Background Screening Unit at [MQA.BackgroundScreen@flhealth.gov](mailto:MQA.BackgroundScreen@flhealth.gov) or mailed to:**

**Background Screening Unit**  
Florida Department of Health  
4052 Bald Cypress Way, Bin BSU-01  
Tallahassee, FL 32399

## 12. LIVESCAN PRIVACY STATEMENT

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation (found in the forms following this application).

**The board will not receive your Livescan results if you do not confirm the above statement by checking the box.**

### **Electronic Fingerprinting:      (Required for ALL applicants)**

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: <http://www.flhealthsource.gov/background-screening/>.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board's ORI number is **EDOH4420Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

Livescan screenings performed by a Florida Police or Sheriff's Department require that you login to the FDLE Civil Applicant Payment System (CAPS) at <https://caps.fdle.state.fl.us> and pay a fee before your results will be released to our office.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided with instructions on how to retain their fingerprints to avoid having to submit a new background screening.

Applicants needing hard fingerprint cards can request them via email at [MQA.BackgroundScreen@flhealth.gov](mailto:MQA.BackgroundScreen@flhealth.gov). Request must include the current mailing address you want the cards mailed to. To find providers who offer this service go to <http://www.flhealthsource.gov/bgs-providers>. Click on the "Out of State/International" link.



## FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

### NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record to be employed, licensed, work under contract, or serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Person with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

**Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same or similar to yours.**

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of your record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in S. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

**The FBI's Privacy Statement follows on a separate page and contains additional information.**



## PRIVACY STATEMENT

**Authority:** The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub. L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

**Social Security Account Number (SSAN).** Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

**Principal Purpose:** Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI (may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

**Routine Uses:** The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosure to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State a local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

**Additional information:** The requesting agency and/or the agency conducting the application investigation will provide additional information to the specific circumstances of this application, which may include identification of other authorities, purposes, uses and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

# Board of Nursing Electronic Fingerprinting



Take this form with you to the Livescan service provider. Check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method;
- You can find Livescan service providers at: <http://www.flhealthsource.gov/background-screening/>
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the board office will not receive your background screening results;
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**;
- The ORI number for the Board of Nursing is **EDOH4420Z**;
- Typically background screening results submitted through a Livescan service provider are received by the board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: \_\_\_\_\_ SSN#: \_\_\_\_\_

Aliases: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
MM/DD/YYYY

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Race: \_\_\_\_\_  
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown)

Sex: \_\_\_\_\_  
(M= Male; F=Female)

Citizenship: \_\_\_\_\_

Transaction Control Number (TCN#): \_\_\_\_\_  
(This will be provided to you by the Livescan service provider.)

**Office staff will attempt to complete verifications online.** If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification.

**Complete verifications must be mailed directly from the licensing agency to:**

**Board of Nursing**  
4052 Bald Cypress Way Bin C-02  
Tallahassee, FL 32399-3252



## **Board of Nursing License Verification Request**

**Part I: To be completed by applicant and submitted to the verifying jurisdiction** (Florida requires verification of all your current and previously held licenses).

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name original license was issued under: \_\_\_\_\_

License Number: \_\_\_\_\_ State: \_\_\_\_\_

*I hereby authorize release of any information regarding my licensure status to the Florida Board of Nursing.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY

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## **Part II: To be completed by state licensing agency**

All verifications must be in English and include the following criteria:

- \* Typed on an official state form or letterhead
- \* Include an official board seal
- \* Signature and title of state board official

The following information must be included in all verifications:

- \* Licensee name
- \* License number
- \* State or jurisdiction of licensure
- \* Licensure status
- \* Is license in good standing?
- \* Date of issuance/expiration
- \* Licensure method (examination, grandfathering, reciprocity/endorsement)
- \* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- \* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.

Complete verifications must be mailed directly from the verifying agency to:

**Board of Nursing**

4052 Bald Cypress Way Bin C-02  
Tallahassee, FL 32399-3252



**Board of Nursing Employment Verification Request**

**Who needs to use this form?**

- Applicants who **have not** taken the NCLEX but have practiced in a U.S. state or territory must show proof of work in a U.S. state or territory for two of the last three years at the level (LPN/RN) of licensure as it relates to the selected application type.
- Applicants who have taken the SBTPE or NCLEX, but **do not have** an active license, and who have worked in the previous five years.

Applicants who have taken the SBTPE or NCLEX and have an active license **DO NOT** need to complete this form.

**Part I: To be completed by applicant** (Complete this section and submit a copy to each place you were employed as a nurse at the level you are applying for during the last three years.)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name of hospital or agency: \_\_\_\_\_

*I hereby authorize release of any information regarding my employment status with your facility to the Florida Board of Nursing.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY

**Part II: To be completed by employer-** All verifications must be in English and mailed directly from the hospital personnel office or agency/employer and must include the following:

- \* Typed on official agency letterhead with an original signature
- \* Applicant name
- \* Applicant's Social Security Number
- \* Indicate level of licensure while employed (Registered Nurse/Licensed Practical Nurse)
- \* Position title while employed
- \* Place of employment
- \* Address of employer (including mailing address, city, state, ZIP, country)
- \* Employer's telephone number (including area code)
- \* Start and end dates of employment (month and year)
- \* Eligible for rehire? (Yes/No) If not eligible for rehire, please provide written details
- \* Printed name of verifying agent
- \* Signature of verifying agent and date completed