Autonomous Advanced Practice Registered Nurse Registration

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

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Autonomous Practice means advanced nursing practice by an advanced practice registered nurse (APRN) who is registered under section (s.) 464.0123, Florida Statutes (F.S.) and who is not subject to supervision by a physician or a supervisory protocol.

1. PERSONAL INFORMATION

Florida APRN License Number: ____________________

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 (Input without dashes)

Physical Location: (Primary Practice Location- This address will be posted on the Department of Health's website.)

______________________________ ________ ____________________
Street Apt. No. City

______________________ ________ ____________ ____________________
State ZIP Country Work/Cell Telephone (Input without dashes)

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. APPLICANT BACKGROUND

A. Have you been subject to disciplinary action as specified in s. 456.072, F.S., or s. 464.018, F.S., or any similar disciplinary action in any state or jurisdiction within the past five years? Yes No

B. Have you completed at least 3,000 clinical practice hours under the supervision of an allopathic or osteopathic physician within the past five years? These hours may include clinical instructional hours. See s. 464.0123(1)(c), F.S., for complete requirements. Yes No

C. Have you submitted proof of three graduate-level semester hours (or the equivalent) in differential diagnosis, and three graduate-level semester hours (or the equivalent) in pharmacology completed within the last five years? Yes No

I state that the information on this form is true and correct.

Applicant Signature ______________________________________ Date ______________
You may print this application and sign it or sign digitally. MM/DD/YYYY

This form is required for all applicants.

Board *of* Nursing
Financial Responsibility

Name: ____

Florida APRN License Number: _________________________

The Financial Responsibility options are divided into two categories: coverage and exemptions.
Choose only ONE option that best describes your situation, unless you choose **option 3** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

1. I have obtained and will maintain professional liability coverage of at least $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F.S., a surplus lines insurer as defined under s. 626.914(2), F.S., a Joint Underwriting Association established under s. 627.351(4), F.S., a self-insurance plan as provided in s. 627.357, F.S., or a risk retention group under s. 627.942, F.S.

2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined by ch. 675, F.S., which is in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000, and which is payable to the APRN as beneficiary.

3. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category on the following page.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILTY COVERAGE

1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. My Florida license is inactive, and I do not practice in the state of Florida.
3. I practice only in conjunction with my teaching duties at an accredited school or its main teaching hospitals.
4. My Florida license is active, but I do not practice in the state of Florida.

Section 456.067, F.S.: Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license from the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.084, F.S.

Licensee Signature: ____ Date: _______________
You may print this application and sign it or sign digitally. MM/DD/YYYY

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