



**Oregon State Board of Nursing**  
 17938 SW Upper Boones Ferry Rd.  
 Portland, OR 97224-7012  
 971-673-0685  
[www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)

# Oregon Application for CNA/CMA Certification by LPN/RN Licensure

**NOTE:** Before submitting an application and fees for Oregon CNA/CMA certification in Oregon, and/or to list a CNA2 Education level on the CNA2 Registry, please review the Oregon Nurse Practice Act, Division 62: *Standards for Certification of the Nursing Assistant and Medication Aide* in order to verify that meet the eligibility requirements. These rules are available on the OSBN website at [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN).

## Section 1: Application Instructions

- **ATTENTION: If you have held an Oregon Certified Nurse Assistant (CNA) certification in the past and it has expired, you must apply to reactivate** the expired certification by using the form *LIC-701 Oregon CNA/CMA Application for Certification by Renewal/Reactivation*, available on the OSBN website at: [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)
- Allow approximately 10 business days from the date the application and full payment are received by OSBN to review application requirements. A student nurse application is **valid for one year from the date full payment is received** and will become null and void upon expiration.
- A national fingerprint-based criminal background check conducted by OSBN is required in order to apply for and obtain licensure/certification in Oregon. Applicants will be charged a separate fee of \$64.50 by Fieldprint Inc., an independent organization contracted by the State of Oregon to provide electronic fingerprinting services. **This fee is payable only to Fieldprint Inc. while registering on their website to schedule an electronic fingerprinting appointment.**
- Once your application and full payment are received, we will send you instructions via email or postal mail (if you do not provide an email address) on how to register with Fieldprint Inc. to schedule and pay for your fingerprinting appointment.
- **If you have been issued a different type of OSBN license/certificate within six (6) months from the date of this application, you do not need to complete a new fingerprint-based background check at this time.** Criminal background checks completed by employers, other agencies, or other state and US jurisdictions cannot be used for OSBN licensure/certification purposes.

**Section 2: Application Fee Table-** Please see below for all fees required in order to process your application.

| Application Type   | Fee         | Description   |
|--|-------------|---|
| Oregon CNA Certification by LPN/RN Licensure (form LIC-706)    | <b>\$60</b> | This application may be submitted by individuals applying for initial Oregon CNA certification who meet eligibility requirements through proof of active, unencumbered LPN or RN state/US jurisdiction-issued licensure.  |
| Oregon CMA Certification by LPN/RN Licensure (form LIC-706)    | <b>\$20</b> | Applicants must meet all eligibility requirements per Oregon Administrative Rule (OAR) 851-062-0090.  |
| Oregon CNA 2 Education Registration (included in form LIC-706) | <b>\$0</b>  | <b>A CNA 2 in Oregon is not issued a separate license number</b> from their CNA certification. <b>It is a <u>continuing education level</u> within a CNA certification</b> that an individual is eligible for, upon completing additional training at a higher skill level. |

## Section 3: Application Checklist

Please review the following checklist items to ensure that you are submitting a completed application for processing.

- All sections of the application are complete, and the authorization sections are signed and dated. **Submit original application to OSBN-** copies are not accepted and will delay processing.
- Submit payment by check or money order made payable to the Oregon State Board of Nursing with your application materials. Failure to submit the correct amount may delay processing. **All application fees are non-refundable.**
- Submit a copy of your active unencumbered state or US jurisdiction-issued LPN/RN licensure with the application.

Mail all application materials and form of payment to:

**Oregon State Board of Nursing**  
**17938 SW Upper Boones Ferry Rd**  
**Portland OR 97224**

**Notice to Applicants with Disabilities:** If you have a disability and require special materials or assistance to complete this application, please contact OSBN at 971-673-0685. If you are hearing impaired, you may contact OSBN through the Oregon Relay Service at 1-800-735-2900.



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**NOTE:** Please read the attached instructions before completing this application. Use only blue or black ink and print all information legibly. Faxed or emailed applications are not accepted.

## Section 1: Application Type- Check all that apply

|   |   |  |
|---|---|--|
| <input type="checkbox"/> <b>New CNA 1</b> by LPN/RN | <input type="checkbox"/> <b>New CMA</b> by LPN/RN | <input type="checkbox"/> <b>CNA2</b> Education Level on Registry |
|---|---|--|

## Section 2: Name and Address Information

|   |  |   |      |
|---|--|---|------|
| Last Name:  |  | First Name:   |      |
| Middle Name:  |  | Former Name(s) Used:                                      |      |
| Address:  |  |   |      |
| City:   |  | State:  | Zip: |
| Country:  |  | Email:  |      |
| Primary Telephone:<br><input type="checkbox"/> Unlisted   |  | Secondary Telephone:<br><input type="checkbox"/> Unlisted |      |
| I prefer to be contacted by: <input type="checkbox"/> telephone <input type="checkbox"/> email <input type="checkbox"/> postal mail |  |   |      |

## Section 3: Personal Identifiers

|   |   |
|---|---|
| Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male   | Date of Birth (mm/dd/yyyy):        /        / |
| Social Security Number (SSN):   |   |
| NOTE: Your SSN is required by the state for child support enforcement, tax administration purposes (including identification), and criminal background checks ONLY. Refusal to provide your SSN may result in denial of issue of a license/certificate and your SSN would be reported to the federal Health Care Integrity and Protection Data Bank, as authorized by ORS 305.385 USC Section 666(a)(13). |   |

## Section 4: LPN/RN License Information

Complete the information below for your active LPN/RN license that makes you eligible for certification. Include a copy of your LPN/RN license with this application.

|  |                     |                                  |
|--|---------------------|----------------------------------|
| Type: <input type="checkbox"/> LPN <input type="checkbox"/> RN | State/Jurisdiction: | Expiration Date:<br>(mm/dd/yyyy) |
| License Number:  |                     |                                  |

OSBN USE ONLY-Applicant Name (last name, first name)

OSBN USE ONLY- Certificate Number & Expiration Date

OSBN USE ONLY- Additional Information  
 LPN/RN License Verified  
 CBC Complete  
 Application Expiration Date: \_\_\_\_\_

**NOTE: This page is for your information only. Please remove this page from your completed application before submitting to OSBN.**

### **Section 5a: Instructions for Disclosure Section**

The following instructions provide you with specific information for what is required to continue processing your application. You are responsible for contacting the appropriate agencies to obtain the required documents to submit with your application. **Please read the following instructions carefully. Your application will not be considered complete until all documents are received.**

#### **Question 1(a) & (b) & (c): Use of Alcohol or Drugs**

If you answered YES to one or more of these questions, provide a detailed written explanation. Describe your alcohol/drug use history and details of any treatment with relevant dates. Provide any available documentation of your sobriety (e.g. letters, program records, or certificates of completion), if applicable.

You may answer NO if: You are currently enrolled in Oregon's Health Professionals Services Program (HPSP) as a **Self-Referral**. "*Self-referral*" means that you have independently and voluntarily enrolled in HPSP, and are being monitored. If you have had a Board investigation that resulted in your enrollment, **you must answer YES**.

#### **Question 2: Ability to Practice Nursing Safely**

If you answered YES, provide a detailed written explanation of your condition, its effects, and how you manage your condition.

#### **Question 3: Criminal History**

If you answered YES, provide a detailed written explanation. Describe the incidents that led to each arrest/charge, and the surrounding circumstances. Include relevant dates, the city and state where the incidents occurred, and the outcome of any criminal charges. Provide a copy of the court judgment and sentencing order or court order of dismissal, and documents providing evidence that you have completed or are in compliance with any court-ordered activities.

#### **Question 4: Investigations for Abuse or Mistreatment**

If you answered YES, provide a detailed written explanation. Provide the name of the agency that conducted the investigation. Provide documentation of the outcome of the investigation and any investigative reports.

#### **Question 5(a) & (b): Investigations for Healthcare Violations**

- a) If you answered YES, provide a detailed written explanation. Describe the alleged violation with relevant dates. Provide the name of the agency that conducted the investigation. Provide documentation of the outcome of the investigation and any investigative reports.
- b) If you answered YES, provide a detailed written explanation. Indicate the law or rule that was found to be violated with relevant dates. Provide documentation of the final determination.

#### **Question 6(a) & (b): Discipline for Healthcare Violations**

If you answered YES, provide a detailed written explanation. Describe the incidents that led to the discipline and the surrounding circumstances with relevant dates. Provide documentation of the final determination.

#### **Question 7: Credentialing Privileges**

If you answered YES, provide a detailed written explanation. Describe the incidents that led to the action against your privileges, and the surrounding circumstances with relevant dates. Provide documentation of the final determination.

#### **Question 8: Malpractice**

If you answered YES, provide a detailed written explanation. Describe the incidents that led to the action for notice or civil judgement against you. Provide documentation of the final determination.

## Section 5b: Disclosure

|  |  |   |                             |
|--|--|---|-----------------------------|
| <p>Before answering the questions below, please review the instructions for information to provide regarding any disclosure(s). Providing false, misleading, or incomplete information is considered falsifying an application and is grounds for denial of your application or discipline on your license/certification. I understand I must provide the Oregon State Board of Nursing (OSBN) with any updates to information required in this application while it is pending.</p> |  |   |                             |
| 1  | a) In the last five years, have you used alcohol or any drugs in a way that could impair your ability to practice nursing or perform nursing assistant duties with reasonable skill and safety?  | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
|  | b) In the last five years, have you been diagnosed with or treated for an alcohol or any drug-related conditions?  | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
|  | c) In the last five years, have you used any illegal drugs, or prescription drugs in a manner other than prescribed?   | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
| <p><b>ATTENTION:</b> You must answer <b>YES</b> if you are enrolled in an impaired nurse program in any state or jurisdiction <b>including Oregon</b>. <b>If you are a self-referral to the Oregon Health Professionals Services Program (HPSP)</b>, please review the disclosure instructions for Question 1 that include the definition of "self-referral", before answering any of these questions.</p>   |  |   |                             |
| 2  | Other than any information you may have provided in Question 1, do you have a physical, mental or emotional condition that could impair your ability to practice nursing or perform nursing assistant duties with reasonable skill and safety?   | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
| 3  | Other than a traffic ticket, have you ever been arrested, cited, or charged with an offense?<br><br><b>ATTENTION:</b> This includes outstanding restraining orders, all arrests, citations, or charges for felony or misdemeanor crimes, <b>even if you were not convicted of any charge</b> (for example- no charges were filed, case was dismissed, or you entered a diversion program). <b>Driving under the influence must be reported here.</b> | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
| 4  | Have you ever been part of an investigation for any type of abuse or mistreatment, in any state or jurisdiction? Include any pending investigations.<br><br><b>ATTENTION:</b> You must answer <b>YES</b> to this question even if the allegation was not substantiated.  | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
| 5  | a) Have you ever been investigated for any alleged violation of any state or federal law, rule, or practice standard regulating a health care profession? Include any pending investigations.  | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
|  | b) Have you ever been found in violation of any state or federal law, rule, or practice standard regulating a health care profession?<br><br><b>ATTENTION:</b> Question 5a) and 5b) include disclosure of any civil, criminal, administrative, licensing, or credentialing proceedings.  | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
| 6  | a) Has an agency ever taken action against any healthcare license or certificate you have held in any other state or jurisdiction?<br><br><b>ATTENTION:</b> Question 6a) includes the disclosure of a denial, revocation, suspension, restriction, reprimand, censure, probation, loss of privileges, or any other formal or informal action.  | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
|  | b) Have you ever withdrawn an application, or surrendered a license or certificate to avoid any of the actions listed above?   | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
| 7  | Have you ever had privileges to practice in a credentialed facility or participation in a federally qualified insurance program (e.g. Medicare or Medicaid) denied, restricted, suspended, revoked, or terminated for cause?   | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |
| 8  | Have you ever had a notice filed or a civil judgement awarded against you for malpractice, negligence, or incompetence relating to your ability to practice as a health care professional?   | <input type="checkbox"/> YES<br>Explain | <input type="checkbox"/> NO |

## Section 6: Authorization

|  |                    |
|--|--------------------|
| <p>I understand I have a duty to provide the Oregon State Board of Nursing with any updates to information required in this application while it is pending. I hereby certify that I have read this application, and that the information provided is true and correct. I have personally completed this application. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or discipline of license/certification. I am aware that the Oregon State Board of Nursing will conduct criminal records checks through the Oregon Law Enforcement Data System (LEDS) and the Federal Bureau of Investigation (FBI).</p> <p><input type="checkbox"/> I do not want my name and address shared with non-state agencies or for non-public health planning purposes. I understand this does not apply to requests made to OSBN for public information as authorized by ORS 192.420.</p> |                    |
| Applicant Signature  | Date (mm/dd/yyyy): |