



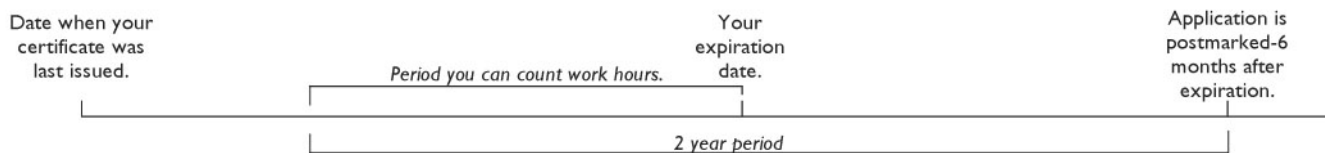
## Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road • Portland, Oregon 97224-7012  
Telephone: 971-673-0685 • Fax: 971-673-0684 • License Verification: 971-673-0679  
E-mail: [oregon.bn.info@state.or.us](mailto:oregon.bn.info@state.or.us) • Website: [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)

# Certification Renewal Application Instructions

## GENERAL INFORMATION

- **Your certificate expires the midnight before your birthday.** Please allow a minimum of 10 working days to process your renewal application, fee and print and mail your certificate. If certification is not renewed by midnight before your birthday, your certificate becomes void. If you work as a nursing assistant or medication aide after your certificate is expired, you may be subject to a civil penalty. *Please note: On-line renewal is now available! Visit our website at [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN) to renew your certificate.*
- If you have been certified for two years or longer and cannot meet the work hour requirement, contact the Oregon State Board of Nursing (OSBN) office at 971-673-0685 for more information before you submit your application.
- Work hours as a Certified Nursing Assistant (CNAI) do not count toward Certified Medication Aide (CMA) renewal.
- The information you provide regarding work hours and any continuing education will be subject to random audits.
- **You can only count work hours obtained while your certificate was active and during the two year period immediately preceding the date your application is postmarked.** Therefore, if you are renewing your certificate after it has expired, you may have a shorter time frame during which you can achieve the minimum 400 paid work hour requirement. **For example:**



- **Fees are non-refundable and processed on receipt.** Even if you do not complete the application process or do not qualify for certification, the fee is not refundable.
- **A background check is performed on every application.** A positive criminal record check will require your application to be reviewed by an OSBN investigator, and could delay the processing of your application.
- If you have a disability that requires special materials or assistance, please contact the OSBN office at 971-673-0685. If you are hearing impaired, you may reach the OSBN through Oregon Relay Service at 1-800-735-2900.

## How to complete the Certification Renewal Application

Please complete the sections that apply to your license type and send the Renewal application with the appropriate fee and any additional requested documentation to the Oregon State Board of Nursing.

## Fee

The fee amounts below apply to payment postmark date. Please read the amounts carefully, as fees paid to the Oregon State Board of Nursing are **not refundable**.

Certificate(s)	On-time Renewal	Late Renewal
	Renewing before expiration date of certification(s)	Renewing after expiration date of certification(s)
<b>CNA I</b>	<b>\$60</b>	<b>\$65</b>
<b>CNA I &amp; CMA</b>	<b>\$75</b>	<b>\$80</b>

**If your Oregon CNA Certification is expired more than 60 days then you must complete a national fingerprint based criminal background check. The fee for fingerprint processing is \$52.00.** Contact the OSBN by sending an email to [osbn.fingerprintinginfo@state.or.us](mailto:osbn.fingerprintinginfo@state.or.us) or call 971-673-0685 for more information.



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### CMA Continuing Education Explanation

How much medication-related continuing education do CMAs need? If you've held your CMA certificate for two years or longer, you need eight hours of continuing education. If you have held your CMA certificate for less than two years, use the formula below:

Months CMA Held	Hours of CE Needed
0 - 3	0
3 - 6	1
6 - 9	2
9 - 12	3
12 - 15	4
15 - 18	5
18 - 21	6
21 - 24	7
24 +	8

## Certification Renewal Checklist

### Complete the Certification Renewal application.

- Remember to sign the application. Applications received without a signature will not be processed.
- Use your legal name on the application.

### Mail all forms and fees to the Oregon State Board of Nursing (OSBN).

- If you are sending your renewal application after the expiration date of your certification, please reference the Fees table included in the instructions for this application.
- Please send check or money order made out to the Oregon State Board of Nursing. Fees paid to the Oregon State Board of Nursing are **not refundable**.

### CMAs Only

Remember to include your continuing education information. If you need additional copies of the CMA Continuing Education Document, it can be printed from the "Forms" page of the OSBN website at [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)

### PREVENT DELAYS

- Read all instructions and complete all questions on the application. If needed, please attach written explanation on a separate sheet of paper. An incomplete or unsigned application will be returned to you.
- Please print clearly.
- If you have changed your name since you were last certified in Oregon, you must send a copy of your marriage license, divorce decree or other legal proof to the OSBN office.
- Sorry, we cannot accept facsimiles (fax) or photocopies of documents required for certification application.



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Please use a black pen or pencil. Avoid "gel" pens, as they bleed through paper.

Certification Renewal Application

For office use only

FEE OWED FOR THIS RENEWAL:

\$

The above fee applies for on-time renewals only. If you are reactivating, additional fees apply. Review the Fee table in the instructions for this application for details. Application fees are non-refundable.

[Empty box for Certification Number]

Certification Number

SECTION 1: CERTIFICATES BEING RENEWED

Which certificate(s) are you renewing? [ ] CNAI only [ ] CNAI & CMA

Check one option: [ ] I am renewing on time. (Review the Fee table in Certification Renewal Application Instructions)
[ ] I am renewing after the expiration date. (Review the Fee table in Certification Renewal Application Instructions)
If renewing 61 or more days after the expiration date, call the OSBN at 971-673-0685 for more information.

SECTION 2: NAME & ADDRESS VERIFICATION

Is the above name and address correct? [ ] Yes [ ] No. If no name and address are printed above, complete this section. If your name has changed, attach copy of name change document(s).

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

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-mail: \_\_\_\_\_ Country: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Unlisted? [ ] Yes [ ] No Contact preference (E-mail, mail, telephone): \_\_\_\_\_

SECTION 3: PERSONAL IDENTIFIERS

Gender (m/f): \_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Refusal to provide a Social Security Number (SSN) may result in denial of license/certification issuance or renewal. This record of your SSN will be used for child support enforcement, tax administration purposes (including identification) and criminal background checks only, unless you authorize other use. If any disciplinary action is taken against your license/certification, your SSN will be reported to the federal Health Care Integrity and Protection Data Bank. Authority: ORS 25.785, ORS 305.385, USC Section 666 (a) (13).

(This question is voluntary) Are you interested in receiving more information regarding Veterans' Benefits and Services? If you answer yes to this question, your name and contact information will be forwarded to the Oregon Department of Veterans' Affairs.

Interested? [ ] Yes [ ] No

**SECTION 4: DISCLOSURE**

Please provide a detailed explanation of any "Yes" answers on a separate sheet of paper. A detailed explanation includes information such as a description of any impairment, investigations, violations, disciplinary actions or judgments. Describe any practice limitations or legal practice proceedings, credentialing actions and incident dates. List arrests, dates, locations and describe circumstances. List any agencies or courts involved, charges, convictions or deferred adjudications (diversion), other outcomes and lessons learned.

If you are reactivating license or certificate (renewing after the expiration date) "date of your last renewal" refers to the period since your last renewal, or when your license or certificate certificate was first active (If you have never renewed your license or certificate).

1. Do you have a physical, mental or emotional condition that in any way impairs or may impair your ability to practice nursing or perform nursing assistant duties with reasonable skill and safety? (If you are in the Nurse Monitoring Program you must answer yes to this question)  Yes (Explain)  No
2. In answering the following questions, please note that if you were arrested or cited for a criminal offense, even if no charges were subsequently filed with a court, you should answer "yes" and provide a detailed explanation.
- 2(a) Have you ever been arrested or cited in lieu of arrest, charged with, entered a plea of guilty or no contest, or convicted of any felony criminal offense?  Yes (Explain)  No
- 2(b) In the 10 years prior to the date of your signature on this application, were you arrested or cited in lieu of arrest, charged with, entered a plea of guilty or no contest, or convicted of any misdemeanor criminal offense, including driving under the influence?  Yes (Explain)  No
- 2(c) Have you ever been arrested or cited in lieu of arrest, charged with, entered a plea of guilty or no contest, or convicted of any misdemeanor criminal offense involving sexual misconduct?  Yes (Explain)  No
3. Are you being investigated currently, or have you been investigated since the "date of your last renewal" (regardless of whether the investigation was substantiated), for any type of abuse or mistreatment in any state?  Yes (Explain)  No
4. Since the "date of your last renewal" have you been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession?  Yes (Explain)  No
5. Since the "date of your last renewal" are any disciplinary actions or judgments pending or have any actions been taken against your nursing license/certificate in any state or US jurisdiction? This includes any civil judgment for incompetence, negligence or malpractice concerning the practice as a health care professional.  Yes (Explain)  No
6. Do you use, or have you used in the time since your last renewal, chemical substance(s) in any way, which impairs or limits your ability to practice nursing or perform as a nursing assistant with reasonable skill and safety? ("Chemical Substance" includes alcohol and drugs).  Yes (Explain)  No
7. Are you currently engaged in the unlawful use of controlled substance(s)?  
Unlawful use of controlled substances means:
- a. The use of controlled substances obtained illegally (For example, marijuana, meth, heroin, cocaine) as well as;  Yes (Explain)  No
- b. The use of legally obtained controlled substances (For example, prescription narcotics or medical marijuana), not taken in accordance with the directions of a licensed health care provider.
8. Since the "date of your last renewal" have you been found in any civil, administrative or criminal proceeding to have possessed, used, prescribed for use, or distributed controlled substances or prescription drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or prescription drugs, violated any drug law or prescribed controlled substances for yourself?  Yes (Explain)  No
9. Since the "date of your last renewal" have you been found in any civil, administrative or criminal proceeding to have committed any act involving dishonesty or corruption, or have you been found to have violated any state or federal law or rule regulating the practice of a health care profession?  Yes (Explain)  No
10. Since the "date of your last renewal" have you had any certificate, license, registration or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, censured or placed on probation by a state, federal, foreign authority or facility, or have you ever surrendered such credential in connection with or to avoid action by such authority or have you ever been denied a license or certificate, or have you ever withdrawn an application for certification or licensure in another State?  Yes (Explain)  No
11. Since the "date of your last renewal" have you had privileges to practice in a credentialed facility or participation in a federally qualified insurance program (such as Medicaid or Medicare) denied, restricted, suspended, revoked or terminated?  Yes (Explain)  No

**SECTION 5: EMPLOYMENT HISTORY**

- The information you provide regarding work hours will be subject to random audits.
- If your answers to questions 2 or 3 in this section are "No", you cannot renew your certificate at this time. Please contact the OSBN office at 971-673-0685 for more information.

1. I have been certified in Oregon for:  Less than 2 years (exempt from work hours requirement)  2 or more years
2. I have worked at least 400 paid hours as a CNA in the last two years with a nurse who supervises or monitors my performance of CNA authorized duties.  Yes  No
3. I have worked at least 400 paid hours as a CMA in the last two years with a nurse who supervises or monitors my performance of CMA authorized duties.  Yes  No

**CURRENT / MOST RECENT EMPLOYER(S):**

Company: _____	Telephone: (____) _____ - _____
Address: _____	Part Time? <input type="checkbox"/> Yes <input type="checkbox"/> No
City: _____	State: ____ Zip: Code: _____ Country: _____
Start Date mm/dd/yyyy) : _____	End Date (mm/dd/yyyy): _____ Hours Worked): _____
Company: _____	Telephone: (____) _____ - _____
Address: _____	Part Time? <input type="checkbox"/> Yes <input type="checkbox"/> No
City: _____	State: ____ Zip: Code: _____ Country: _____
Start Date mm/dd/yyyy) : _____	End Date (mm/dd/yyyy): _____ Hours Worked): _____

**SECTION 6: CMA CONTINUING EDUCATION**

To meet the continuing education requirement, I have:

- Completed 8 or more hours of medication-related continuing education in the last two years.
- Been certified as a CMA less than 2 years (date original CMA issued) mm/dd/yyyy\_\_\_\_/\_\_\_\_/\_\_\_\_ ) and completed \_\_\_\_\_ hours of medication-related continuing education.
- Neither of the above apply (Provide written explanation on a seperate sheet of paper).

Document below any continuing education classes you have taken during this renewal cycle. List additional classes on a separate sheet. The CMA Continuing Education form is available online at [www.oregon.gov/OSBN/pdfs/forms/CMA\\_continuing\\_ed.pdf](http://www.oregon.gov/OSBN/pdfs/forms/CMA_continuing_ed.pdf)

Class Title: _____	Class Length (in hours): _____
Exact date(s) of class: _____	Class Location: _____
Instructor's name: _____	Instructor's phone number: _____
Instructor's title: _____	
Describe class content: _____	
Class Title: _____	Class Length (in hours): _____
Exact date(s) of class: _____	Class Location: _____
Instructor's name: _____	Instructor's phone number: _____
Instructor's title: _____	
Describe class content: _____	
Class Title: _____	Class Length (in hours): _____
Exact date(s) of class: _____	Class Location: _____
Instructor's name: _____	Instructor's phone number: _____
Instructor's title: _____	
Describe class content: _____	

**SECTION 7: WORKPLACE DEMOGRAPHICS**

Please note: **Primary** means the position/setting at which you spend the most time working. **Part-time** means 30-hours or less a week.

**Employment Status:** (Check primary status)

<input type="checkbox"/> Full-time in Oregon	<input type="checkbox"/> Part-time in another State	<input type="checkbox"/> Unemployed, not seeking work in nursing
<input type="checkbox"/> Full-time in another State	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Unemployed, seeking work in nursing
<input type="checkbox"/> Part-time in Oregon	<input type="checkbox"/> Temporary in Oregon	<input type="checkbox"/> Volunteer- Unpaid

**Ethnicity:** (Check one. Optional)

<input type="checkbox"/> African American/Black	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander
<input type="checkbox"/> Asian (e.g., Filipino, Japanese, Chinese, etc.)	<input type="checkbox"/> Multi-ethnic or racial background
<input type="checkbox"/> Caucasian/White	

**Other Languages:** (Spoken adequately for clinical purposes. Optional.)

<input type="checkbox"/> Chinese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Russian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Sign Language
<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other	

**Education:** (Check all that apply)

<input type="checkbox"/> High School / GED	<input type="checkbox"/> Doctorate Degree in nursing	<input type="checkbox"/> Bachelor's Degree (other)
<input type="checkbox"/> Associate Degree in nursing	<input type="checkbox"/> Diploma Nursing Program	<input type="checkbox"/> Master's Degree (other)
<input type="checkbox"/> Bachelor's Degree in nursing	<input type="checkbox"/> Post-Master's Certificate	<input type="checkbox"/> Doctorate Degree (other)
<input type="checkbox"/> Master's Degree in nursing	<input type="checkbox"/> Associate Degree (other)	

**Work Setting:** (Check primary area)

<input type="checkbox"/> Agency or Travel Nurse	<input type="checkbox"/> Home Health / Hospice	<input type="checkbox"/> Nursing Home / Extended Care Facility	<input type="checkbox"/> Public / Community Health
<input type="checkbox"/> Ambulatory Surgical Center	<input type="checkbox"/> Hospital	<input type="checkbox"/> Occupational Health Clinic	<input type="checkbox"/> Residential Care Facility
<input type="checkbox"/> Ambulatory Urgent / Emergency	<input type="checkbox"/> Insurance / Managed Care	<input type="checkbox"/> Office / Clinic	<input type="checkbox"/> Retired
<input type="checkbox"/> Assisted-Living	<input type="checkbox"/> Military	<input type="checkbox"/> Other	<input type="checkbox"/> School Health
<input type="checkbox"/> Community Based Group Home	<input type="checkbox"/> None	<input type="checkbox"/> Primary Care	<input type="checkbox"/> State or Federal Agency
<input type="checkbox"/> Drug / Alcohol Center	<input type="checkbox"/> Nursing Education Program	<input type="checkbox"/> Private Duty	

**Practice Area:** (Check primary area)

<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Critical Care / ICU / CCU	<input type="checkbox"/> Dermatology / Aesthetics
<input type="checkbox"/> Emergency / Urgent Care	<input type="checkbox"/> Family Practice	<input type="checkbox"/> Gerontology
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Medical-Surgical	<input type="checkbox"/> Neonatology
<input type="checkbox"/> Neurology	<input type="checkbox"/> None	<input type="checkbox"/> Nursing Education
<input type="checkbox"/> OB / GYN / Women's Health	<input type="checkbox"/> Occupational Health	<input type="checkbox"/> Oncology
<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Other	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Psych/Mental Health	<input type="checkbox"/> Regulation	<input type="checkbox"/> Rehabilitation
<input type="checkbox"/> Surgery / Recovery		

**Position:** (Check primary area)

<input type="checkbox"/> Staff Nurse	<input type="checkbox"/> CNA	<input type="checkbox"/> CMA
<input type="checkbox"/> Advanced Practice (CNS, NP, CRNA)	<input type="checkbox"/> Education - Healthcare Facility	<input type="checkbox"/> Health Care Administration
<input type="checkbox"/> Lead Nurse	<input type="checkbox"/> None	<input type="checkbox"/> Nurse Consultant
<input type="checkbox"/> Nursing Education - School of Nursing	<input type="checkbox"/> Nurse Manager / Supervisor	<input type="checkbox"/> Other
<input type="checkbox"/> Private Duty	<input type="checkbox"/> Quality Management	<input type="checkbox"/> Researcher

**Primary Population Served**  Senior/Geriatric  Pediatric (18 and under)  Adult

**In the next three years, I plan to:**

<input type="checkbox"/> Maintain my practice as is.	<input type="checkbox"/> Increase my practice hours.	<input type="checkbox"/> Move out of state.
<input type="checkbox"/> Significantly reduce practice (patient care) hours.	<input type="checkbox"/> Move my practice to another Oregon location.	<input type="checkbox"/> Retire.
<input type="checkbox"/> None of the above.		

**When do you plan to retire?**

<input type="checkbox"/> Already retired.	<input type="checkbox"/> Within the next 5 years.	<input type="checkbox"/> Within the next 6-10 years.
<input type="checkbox"/> More than 10 years from now. <input type="checkbox"/> Don't know / Uncertain.		

**SECTION 8: CERTIFYING STATEMENT**

I hereby certify that I have read this application. I also certify that the information provided on this application is true and correct and that I have personally completed this application. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation 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).

**Printed Name:** \_\_\_\_\_

**Date (mm/dd/yyyy):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

(Application will not be processed without signature.)