



Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road • Portland, OR 97224-7012

Phone: 971-673-0685 • Fax: 971-673-0684 • Website/Verification: www.oregon.gov/OSBN

Clinical Nurse Specialist (CNS) Information

Attention

- You must have a current, unencumbered, and valid Oregon RN license before you can be certified as a Clinical Nurse Specialist (CNS). If you are not currently licensed as an Oregon RN, or have not filed an application for Oregon RN licensure, you must do so. Your CNS certificate will be issued simultaneously with your RN license when you have met all the requirements for both licensure and certification.
- You must hold a current and valid Oregon CNS Certificate **before** you practice as a CNS, sign your name, initials or otherwise identify yourself to the public as a CNS. As of October 1, 2001, indicating you are a CNS, unless certified by the Oregon State Board of Nursing, may result in a civil penalty up to \$5,000.

Fee

Application	Fee	Explanation
Clinical Nurse Specialist (CNS)	\$150	Required to be certified as a CNS in Oregon.
Prescriptive Authority	\$75	Optional. (See additional information below.)
Prescriptive Authority Practicum Limited License	\$95	Oregon CNS applying for Prescriptive Authority who does not have prior clinical prescribing practicum or Prescriptive Authority. (Contact the Board office for information.)
Criminal Background Check	\$52	Contact the Board office to obtain a National Criminal Background check packet.
Re-Entry Limited License	\$95	Oregon CNS who does not meet the practice requirement for renewal of certification. (Contact the Board office for information.)

Prescriptive Authority

Prescriptive Authority is optional for the CNS. Requirements include pharmacology, physical assessment, differential diagnosis, and pathophysiology coursework along with a pharmacotherapeutic management practicum. Please see appropriate forms for details or contact the OSBN directly for an application.

Requirements

To be certified as a Clinical Nurse Specialist (CNS) in Oregon you must meet educational and practice requirements per OAR 851-054-0040 :

- Hold a current, unencumbered Oregon Registered Nurse license.
- Hold a graduate degree in nursing or a post-masters certificate in nursing demonstrating CNS theory and clinical concentration. Acceptable programs require NLNAC or CCNE accreditation.
- Practice within the RN/CNS scope of practice for at least 960 hours within the five years preceding the application. Graduation from a CNS educational program within the past five years meets the practice requirement.
- Applicants who graduate or obtain a post-masters certificate on or after **January 1, 2007** must have completed a minimum of 500 hours of supervised clinical practice within the program. Please contact the Board for academic options if your program did not contain 500 hours of clinical practice.

Renewal Information

- **RN and CNS.** Both licenses will be issued simultaneously and both must be unencumbered in Oregon.
- **Practice Requirement.** Practice as a CNS for no less than 960 hours within the five years before the renewal expiration date or have completed a preceptorship. Falsification of practice hours is grounds for disciplinary action.
- **Continuing Education Requirement without Prescriptive Authority.** Documentation of 40 contact hours must be supplied with each renewal application. At least 50% of these hours must be CME or CE accredited. A form is available on the OSBN website for your use or may be requested. These CE hours are subject to random audits. Falsification of continuing education is grounds for disciplinary action. The form for CE records must be maintained for five years from date submitted to the Board. For more information please visit the Continuing Education Frequently Asked Questions (FAQ) page of the OSBN website. New graduates that have graduated less than two years previous to application date will have CE hours prorated.
- **Continuing Education Requirement with Prescriptive Authority.** Documentation of 100 contact hours must be supplied with each renewal application. At least 50% of these hours must be CME or CE accredited. Hours submitted must include at least 15 hours of pharmacologic content. A form is available on the OSBN website for your use or may be requested. These CE hours are subject to random audits. Falsification of continuing education is grounds for disciplinary action. The form for CE records must be maintained for five years from date submitted to the Board. For more information please visit the Continuing Education Frequently Asked Questions (FAQ) page of the OSBN website. New graduates who have graduated less than two years previous to application date will have CE hours prorated.
- **No Grace Period.** An applicant whose CNS certification is expired may not practice as a CNS until certification is complete, subject to civil penalty.
- **Please allow a minimum of 10 business days to process the renewal paper application** and fee, print and mail your license and / or certificate. *Please note: On-line renewal is now available! Visit our website at **www.oregon.gov/OSBN** to renew your license / certificate on-line.*



CNS Application Checklist

- Have a current Oregon RN license.** If you do not have current RN licensure, ensure that the process is completed.
- Complete the application for certification as a Clinical Nurse Specialist (CNS).**
 - Use your legal name on the application. It must be the same name used on your RN license.
 - Applications not completed within one calendar year become void. After one year, you must complete a new application and pay another fee.
 - Complete and sign the application. Applications received without a signature will not be accepted.
- Include photocopies of your current CNS and RN license(s)** with the application, if licensed in another state.
- Complete the additional application for Prescriptive Authority. This is optional for a CNS.**
 - Read the booklet titled, *Prescriptive Authority in Oregon for Nurse Practitioners and Clinical Nurse Specialists*. This booklet is also available on the OSBN website at: http://www.oregon.gov/OSBN/pdfs/publications/prescriptive_booklet.pdf
 - Sign and return the postcard attesting knowledge of Oregon and federal pharmacy law. The required confirmation statement postcard is also available as the last two pages of the booklet which can be printed out, signed and included with your application documents.
- Mail application(s) and non-refundable fee to the Oregon State Board of Nursing (OSBN).**

If you are applying for Prescriptive Authority, you must complete the separate Prescriptive Authority application and fee. All fees are non-refundable and cover the costs of application processing.
- Mail request to school for an official, final transcript from your Masters degree program.**

The official transcript must be mailed directly from your Masters degree program to OSBN. If your CNS program was not within your Masters program, request that an official transcript also be mailed from your CNS program to OSBN. The transcript must be imprinted with an official seal, bear the appropriate registrar's signature and must show completion date and degree granted. A **Licensure Transcript Request** form is included with this application packet for your convenience.
- Mail the *Verification of Successful Completion of an Advanced Practice Nursing Program* form to the school where you obtained your CNS education.** Request that the form be completed and mailed to OSBN with the required attachments.
- Contact OSBN at 9710-673-0685 to obtain a National Criminal Background Check packet.**

Notice to Applicants with Disabilities: If you have a disability and require special material or assistance, please contact the Board office 971-673-0685. If you are hearing impaired, you may reach the OSBN through the Oregon Relay Service, 1-800-735-2900.



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Licensure/Certification General Information

Please Note

If you held an Oregon nursing license/certificate in the past, call the Oregon State Board of Nursing (OSBN) and ask for information about reactivation.

Application

- Apply for licensure/certification well in advance of employment in Oregon. In some cases, it can take several weeks for information from schools and other agencies to arrive for processing. If you meet the requirements for licensure/certification, your license will be issued approximately five business days after we have reviewed all of the required information and have determined eligibility.
- OSBN may deny licensure/certification to an applicant convicted of certain crimes. If you have a criminal history, you will need to report it on your application and attach explanatory information on a separate sheet of paper. Falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of licensure/certification. A positive criminal record check will require investigation and may delay processing. Practicing before you are licensed/certified may result in a civil penalty.
- Your license/certification will be issued using the name on the initial application. If you change your name before or after issue, submit legal documentation of your name change.
- Your mailing address must be complete and current with OSBN at all times.

Fees

- Fees are non-refundable and processed on receipt. Even if you do not complete the application process or do not qualify for licensure/certification, the fee is not refundable. The fee pays for processing the application and, if you are eligible, issuing the license/certificate.
- A canceled check is your receipt and notification that OSBN has received the application.

Renewal

- Oregon uses a biennial birth date renewal system. When you receive your license/certificate, please note the expiration date. The expiration date is the midnight before your birthday in an odd year if you were born in an odd year or in an even year if you were born in an even year. Because of this, your first license/certificate may be valid anywhere from 60 days to two years and 59 days depending upon when you were born and when your application is complete. After that, if renewed on schedule, your license/certificate is good for two years.
- Your license is valid until the expiration date noted on the OSBN License Verification system at <http://www.oregon.gov/OSBN>. There is no grace period permitting practice beyond this expiration date.
- You will renew all licenses/certificates simultaneously.
- Notify the OSBN in writing when you change your address to prevent delays in receiving your renewal notice.

Additional Information

- 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).
- 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 OSBN through the Oregon Relay Service, at 1-800-735-2900.
- Information about nursing practice in Oregon can be found at the OSBN website at www.oregon.gov/OSBN
- Call OSBN at 971-673-0685 if you need additional information.
- License/certificate verification is available at <http://www.oregon.gov/OSBN>



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

Clinical Nurse Specialist Application

For office use only

Fee Owed For this Application:

\$ 150.00

The above fee is non-refundable and applies only for this Application for Clinical Nurse Specialist. Checks should be made payable to the Oregon State Board of Nursing.

Section 1: License Type

For which license are you applying? [] CNS [] CNS with Prescriptive Authority (Optional)

Section 2: Name & Address

Last Name: _____

First Name: _____ Middle Name: _____

Former/Maiden Name(s): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Home Telephone: (____) ____ - ____ Work Telephone: (____) ____ - ____
Unlisted? [] Yes [] No

Section 3: Personal Identifiers

Date of Birth (mm/dd/yyyy): ____/____/____ Country of Birth: _____

City of Birth: _____ State of Birth: _____ Gender: [] Female [] Male

- Ethnicity: (Optional. Check one)
[] African American/Black [] Caucasian/White
[] American Indian/Alaska Native [] Hispanic or Latino
[] Asian (e.g., Filipino, Japanese, Chinese, etc.) [] Native Hawaiian/Other Pacific Islander
[] Multi-ethnic or racial background

Social Security Number: ____ - ____ - ____

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

Consultant's Approval _____ Date _____
RN License # _____ Adv Prx License # _____

Section 4: Oregon Registered Nurse obtained By:

You must have a current, unencumbered Oregon RN license before obtaining CNS licensure. Please check which RN license application you have on file or are filing.

- Renewal
- Reactivation
- Endorsement
- Examination

Original State : _____

Section 5: Original License Information

List all states in which you have ever been licensed as a CNS. If none, check here:

License type State License number

License type State License number

License type State License number

License type State License number

License type State License number

License type State License number

Section 6: Advanced Practice Legal / Discipline

Please provide a detailed explanation of any "Yes" answers on a separate sheet of paper.

1. Do you have a physical, mental or emotional condition that in any way impairs or may impair your ability to practice nursing with reasonable skill and safety? YES (Explain) NO

2. Have you ever been arrested, charged with, entered a plea of guilty, no contest, convicted of or been sentenced for any criminal offense either misdemeanor or felony, including driving under the influence, in any state? YES (Explain) NO

3. Have you ever been investigated for any type of abuse in any state? YES (Explain) NO

4. Have you ever 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. Are any disciplinary actions pending against your nursing license/certificate in any state or US jurisdiction? YES (Explain) NO

6. Have any disciplinary actions been taken against your nursing license/certificate in any state or US jurisdiction? YES (Explain) NO

7. Have you ever suffered any civil judgement for incompetence, negligence or malpractice concerning the practice as a health care professional? YES (Explain) NO

8. Do you use, or have you used in the last five years, chemical substance(s) in any way, which impairs or limits your ability to perform as a nurse with reasonable skill and safety? (*"Chemical Substance" includes alcohol and drugs.*) YES (Explain) NO

9. Are you currently engaged in the unlawful use of controlled substance(s)? (*Unlawful use of controlled substances means the use of controlled substances obtained illegally (e.g. marijuana, meth, heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care provider.*) YES (Explain) NO

10. Have you ever been found in any civil, administrative or criminal proceeding to have:
 - a. Possessed, used, prescribed for use or distributed controlled substances or prescription drugs in any way other the legitimate or therapeutic purposes, diverted controlled substances or prescription drugs, violated any drug law or pi controlled substances for yourself? a. YES (Explain) NO
 - b. Committed any act involving dishonesty or corruption? b. YES (Explain) NO
 - c. Violated any state or federal law or rule regulating the practice of a health care profession? c. YES (Explain) NO

11. 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? YES (Explain) NO

12. Have you ever 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 7: CNS Education History

- Please complete the requested information for all education programs being submitted for Advanced Practice eligibility.
- Please do not attach resume and do not list individual coursework.
- Request your RN and CNS program/schools to send your official transcript directly to the OSBN for processing.
- Begin with most recently completed education program and work backwards in time.

_____ School Name		
_____ City	_____ State	_____ Country
Degree/Certificate Earned:		
<input type="checkbox"/> LPN/LVN Certificate	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Doctorate Degree
<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor's Degree in Nursing	<input type="checkbox"/> Doctorate Degree in Nursing
<input type="checkbox"/> Associates Degree	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Post-Master's Certificate
<input type="checkbox"/> Associates Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing	<input type="checkbox"/> Other
____ / ____ / ____ Date Enrolled (mm/dd/yyyy)	____ / ____ / ____ Date Graduated (mm/dd/yyyy)	_____ Major
_____ Name Listed on Transcript	_____ Specialty/Type	

_____ School Name		
_____ City	_____ State	_____ Country
Degree/Certificate Earned:		
<input type="checkbox"/> LPN/LVN Certificate	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Doctorate Degree
<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor's Degree in Nursing	<input type="checkbox"/> Doctorate Degree in Nursing
<input type="checkbox"/> Associates Degree	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Post-Master's Certificate
<input type="checkbox"/> Associates Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing	<input type="checkbox"/> Other
____ / ____ / ____ Date Enrolled (mm/dd/yyyy)	____ / ____ / ____ Date Graduated (mm/dd/yyyy)	_____ Major
_____ Name Listed on Transcript	_____ Specialty/Type	

_____ School Name		
_____ City	_____ State	_____ Country
Degree/Certificate Earned:		
<input type="checkbox"/> LPN/LVN Certificate	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Doctorate Degree
<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor's Degree in Nursing	<input type="checkbox"/> Doctorate Degree in Nursing
<input type="checkbox"/> Associates Degree	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Post-Master's Certificate
<input type="checkbox"/> Associates Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing	<input type="checkbox"/> Other
____ / ____ / ____ Date Enrolled (mm/dd/yyyy)	____ / ____ / ____ Date Graduated (mm/dd/yyyy)	_____ Major
_____ Name Listed on Transcript	_____ Specialty/Type	

Section 8: RN and CNS Nursing Practice History

- Please complete the requested information for all of your nursing practice, paid or unpaid, for the last five years.
- You may submit a narrative explanation of your nursing practice, as long as it contains the same information requested on this form.
- Begin with your most recent employer and work backwards in time.
- You may make additional copies as necessary.

_____		(____)____-_____	
Company Name		Telephone number	
_____		_____	
Address		License number State	
_____		_____	
City		State Zip code Position Title	
____/____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/_____	Paid practice?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Start Date (mm/dd/yyyy)	Still Employed?	End Date (mm/dd/yyyy)	Part Time?: <input type="checkbox"/> Yes <input type="checkbox"/> No # Practice Hours
Check all duties that apply to your CNS scope of practice with this employer:			
<input type="checkbox"/> Individual client care based on theory and research.			
<input type="checkbox"/> Population care by collecting data, planning health interventions, and implementation of results.			
<input type="checkbox"/> Providing clinical expertise and guidance to the nurses and other members of the multidisciplinary care team.			
<input type="checkbox"/> Practicing with organizations to provide clinical expertise and guidance.			
<input type="checkbox"/> Providing expertise in research, training, and mentoring health care members.			
<input type="checkbox"/> Other : _____			

_____		(____)____-_____	
Company Name		Telephone number	
_____		_____	
Address		License number State	
_____		_____	
City		State Zip code Position Title	
____/____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/_____	Paid practice?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Start Date (mm/dd/yyyy)	Still Employed?	End Date (mm/dd/yyyy)	Part Time?: <input type="checkbox"/> Yes <input type="checkbox"/> No # Practice Hours
Check all duties that apply to your CNS scope of practice with this employer:			
<input type="checkbox"/> Individual client care based on theory and research.			
<input type="checkbox"/> Population care by collecting data, planning health interventions, and implementation of results.			
<input type="checkbox"/> Providing clinical expertise and guidance to the nurses and other members of the multidisciplinary care team.			
<input type="checkbox"/> Practicing with organizations to provide clinical expertise and guidance.			
<input type="checkbox"/> Providing expertise in research, training, and mentoring health care members.			
<input type="checkbox"/> Other : _____			

_____ (____)_____-_____
 Company Name Telephone number

_____ License number State
 Address

_____ State Zip code Position Title
 City

____/____/____ Still Employed? Yes No Paid practice?: Yes No
 Start Date (mm/dd/yyyy) End Date (mm/dd/yyyy) Part Time?: Yes No # Practice Hours

Check all duties that apply to your CNS scope of practice with this employer:

- Individual client care based on theory and research.
- Population care by collecting data, planning health interventions, and implementation of results.
- Providing clinical expertise and guidance to the nurses and other members of the multidisciplinary care team.
- Practicing with organizations to provide clinical expertise and guidance.
- Providing expertise in research, training, and mentoring health care members.
- Other : _____

_____ (____)_____-_____
 Company Name Telephone number

_____ License number State
 Address

_____ State Zip code Position Title
 City

____/____/____ Still Employed? Yes No Paid practice?: Yes No
 Start Date (mm/dd/yyyy) End Date (mm/dd/yyyy) Part Time?: Yes No # Practice Hours

Check all duties that apply to your CNS scope of practice with this employer:

- Individual client care based on theory and research.
- Population care by collecting data, planning health interventions, and implementation of results.
- Providing clinical expertise and guidance to the nurses and other members of the multidisciplinary care team.
- Practicing with organizations to provide clinical expertise and guidance.
- Providing expertise in research, training, and mentoring health care members.
- Other : _____

Section 9: Certifying Statement

I hereby certify that I have read this application, that I have personally completed this form, and that the information provided on this form is true, correct, and complete to the best of my knowledge. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of licensure/certification. I am aware that the Oregon State Board of Nursing will conduct a criminal records check through the Law Enforcement Data System (LEDS). I am aware that if any disciplinary action is taken against my license, my social security number will be reported to the federal Health Care Integrity and Protection Data Bank.

Printed Name: _____ Date (mm/dd/yyyy): ____/____/____

Signature: _____

(Application will not be processed without signature.)



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Nursing Education History

Please type or print clearly using blue or black ink

- Please provide the requested information below for all nursing education programs completed.
- Please do not attach resume and do not list individual courses taken or continuing education.
- Sealed nursing transcripts should be delivered directly to the Oregon State Board of Nursing (OSBN) from your school(s). *If you completed nursing education outside the United States, your credentials evaluation must be provided to OSBN directly from the credentials evaluation service.*
- **Begin with most recently completed nursing program and work backwards in time.**

Last Name	First Name	Social Security Number
		-- --

School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate	<input type="checkbox"/> Associate Degree in Nursing
<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Master's Degree
<input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing
	<input type="checkbox"/> Doctorate Degree
	<input type="checkbox"/> Doctorate Degree in Nursing
	<input type="checkbox"/> Post-master's Certificate
	<input type="checkbox"/> Other: _____
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	

School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate	<input type="checkbox"/> Associate Degree in Nursing
<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Master's Degree
<input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing
	<input type="checkbox"/> Doctorate Degree
	<input type="checkbox"/> Doctorate Degree in Nursing
	<input type="checkbox"/> Post-master's Certificate
	<input type="checkbox"/> Other: _____
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	

School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Associate Degree <input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Associate Degree in Nursing <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Master's Degree in Nursing
<input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Doctorate Degree in Nursing <input type="checkbox"/> Post-master's Certificate <input type="checkbox"/> Other: _____	
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	

School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Associate Degree <input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Associate Degree in Nursing <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Master's Degree in Nursing
<input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Doctorate Degree in Nursing <input type="checkbox"/> Post-master's Certificate <input type="checkbox"/> Other: _____	
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	

School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Associate Degree <input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Associate Degree in Nursing <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Master's Degree in Nursing
<input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Doctorate Degree in Nursing <input type="checkbox"/> Post-master's Certificate <input type="checkbox"/> Other: _____	
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	



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Licensure Transcript Request

Section I : To be completed by applicant

Make as many copies as needed to request transcripts from the schools attended. Most schools require a fee to prepare a transcript. To avoid delays, contact your school(s) and inquire about the fee.

Send this form with Section I completed and the fee to the school.

Applicant Name : _____

Mailing Address : _____

City, State, and Zip Code : _____

Contact Telephone Number : () _____

Name on transcript : _____

Date of Birth : _____

Social Security Number : _____

Year of Graduation : _____

Degree Attained : _____

Signature of Applicant

Date Signed

Section II : Instructions for the school Registrar's office

Please attach this request to the transcript. The request may contain a current name that is different from the name on the transcript. **The transcript must show the school's official seal, bear the appropriate Registrar's signature, degree awarded, and date the degree was awarded.**

Please send official transcripts directly by mail to:

**Oregon State Board of Nursing
17938 SW Upper Boones Ferry Road
Portland, OR 97224-7012**



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Verification of Successful Completion of Advanced Practice Nursing Program (APRN)

Please type or print clearly using blue or black ink both front and back of application

Attach program requirements and course descriptions matching transcript of student.

Section I: To be completed by the Applicant. Complete Section I and then mail this form to educational institution to complete Section II for program verification.

Last Name First Name Middle Name Former or Maiden

Social Security Number (optional) or School Identification Number

Mailing Address City State Zip Code

() Area Code Home Telephone Unlisted Email Address

I authorize my school program to release the information requested below to the Oregon State Board of Nursing.

Signature Date

Section II: To be completed by the Program. Complete the remainder of this form with responses for the time during which the applicant was enrolled. Please mail the completed form to the Oregon State Board of Nursing.

Certificate/Degree Awarded (Specify) Date Awarded

Name of School

School Mailing Address City State Zip Code

School Accreditation (Name of agency or association) Approval Date Expiration Date

Lecture/Didactic (Total number of classroom hours or academic credits awarded)

Supervised Clinical Practice (Number of hours) Clinical Site

Practicum included 150 or more hours of differential diagnosis and applied pharmacological management of individual patients? Yes No; Approximate number of hours completed

Name and Title of Program Advisor/Director Contact telephone number

Section II (Continued):

In order to assist the Oregon State Board of Nursing in evaluating the eligibility of the above applicant, who graduated from your program, please affirm that the program met the following criteria at the time the student attended.

If applicant was prepared as a Nurse Practitioner list specialty: _____

Program Information : The course numbers must match transcript awarded for time period applicant enrolled. Attach a copy of the **☐** program requirements.

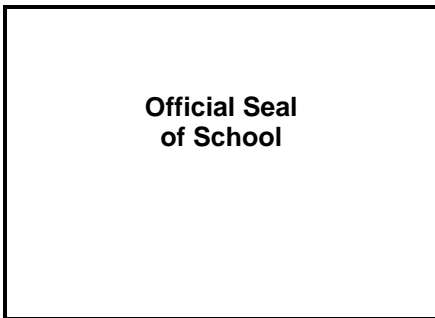
- 1. Was the program at least one academic year in length? YES NO
- 2. Did the program include theory in the biological, behavioral, nursing and medical sciences? YES NO
- 3. Did the applicant have clinical experience with a qualified preceptor? YES NO
- 4. Are the philosophies, purposes and objectives clearly defined and available in written formats? YES NO
- 5. Were the objectives stated in behavioral terms and do they describe the competencies of the graduate? YES NO
- 6. Did faculty include currently practicing advanced practice nurses? YES NO
- 7. Were records of the program, philosophy, objectives, administration, faculty, curriculum, students and graduates maintained systematically? YES NO
- 8. Are the records of the program retrievable? YES NO

Curriculum : Identify the course(s) where the following content/skills were taught correlating with transcripts. Attach a copy of the **☐** course descriptions for the program matching the transcripts.

- | | Specific Course Number
(N/A if not applicable) |
|---|---|
| 1. Theory and directed clinical experience in physical assessment. | _____ |
| 2. Interviewing and communication skills relevant to obtaining and maintaining a health history. | _____ |
| 3. Pharmacology, including selecting, prescribing, initiating, and modifying medications in the management of health/illness. | _____ |
| 4. Advanced physiologic and pathologic mechanisms of disease. | _____ |
| 5. Performance and interpreting specialized diagnostic tests essential to the area of advanced practice. | _____ |
| 6. Differential diagnosis pertinent to the specialty area. | _____ |
| 7. Professional socialization and/or role realignment. | _____ |
| 8. Legal implications of the advanced nursing practice. | _____ |
| 9. Health delivery systems, including assessment of community resources and referrals to appropriate professionals or agencies. | _____ |
| 10. Research and statistical methods. | _____ |

I attest that this nurse was educated for advanced practice in (clinical area) _____

With the role of Certified Registered Nurse Anesthetist Clinical Nurse Specialist Nurse Practitioner.



()

Print Name _____ Telephone Number _____

Title _____

Signature _____



Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road • Portland, OR 97224-7012

Phone: 971-673-0685 • Fax: 971-673-0684 • Website/Verification: www.oregon.gov/OSBN

Prescriptive Authority Information

Attention

You must have either a current, unencumbered Nurse Practitioner (NP) or Clinical Nurse specialist (CNS) certification in Oregon, or apply for and meet the requirements for prescriptive authority concurrent with your application for NP or CNS certification.

Fee

Fees paid to the Oregon State Board of Nursing (OSBN) are not refundable. The application fee for Prescriptive Authority in Oregon is \$75.00.

Please note: *If a Prescriptive Authority Practicum Limited License is required, the separate Prescriptive Authority Practicum Limited License application and an additional \$95.00 will need to be submitted.*

If you have current prescriptive authority:

- If you have current prescriptive authority in another state, US jurisdiction, federal institution or facility and **have** been prescribing or utilizing prescriptive authority at least 400 hours in the last two years, submit a completed Prescriptive Authority application and application fee.
- If you have current prescriptive authority in another state, US jurisdiction, federal institution or facility but have not been prescribing or utilizing prescriptive authority at least 400 hours in the last two years, please contact OSBN at 971-673-0685 for instructions.

If you have never had prescriptive authority:

Please review the following three scenarios to determine which application(s) to submit to OSBN for processing.

Scenario One

I graduated from an NP or CNS program within the past two years which included a 45 contact hour pharmacology course and clinical practicum in prescribing for individual patients of at least 150 hours.

I need to send :

- 1) Prescriptive Authority application

Scenario Two

I graduated from an NP or CNS program within the past two years which included a 45 contact hour pharmacology course but the program did *not* have clinical practicum in prescribing for individual patients.

I need to send :

- 1) Prescriptive Authority application
- 2) Prescriptive Authority Practicum Limited License application (*Contact OSBN for this additional application*)
- 3) Preceptor Agreement for Clinical Practicum in Pharmacological Management form
- 4) Clinical Practicum in Pharmacological Management Evaluation form (*This form to be completed and submitted when clinical practicum has been completed.*)

Scenario Three

I graduated from an NP or CNS program more than two years ago.

I need to send :

- 1) Prescriptive Authority application
- 2) Prescriptive Authority Practicum Limited License application (*Contact OSBN for this additional application*)
- 3) Preceptor Agreement for Clinical Practicum in Pharmacological Management form
- 4) Proof of completion of 45 hour pharmacology course within the past 2 years
- 5) Clinical Practicum in Pharmacological Management Evaluation form (*This form to be completed and submitted when clinical practicum has been completed.*)

How To Meet Oregon Prescriptive Authority Requirements

Oregon requires education and clinical practicum to meet the requirements for prescriptive authority. The following may be used to meet the requirement. To help avoid delay in processing your application, please provide applicable documentation with your Prescriptive Authority application.

Pharmacotherapeutic Education Requirement

- 1) **Completion of a 45 hour pharmacology course including content congruent with the specialty scope of practice (NP or CNS) sought in Oregon. I have met this requirement through one of the following:**
- a) Graduation from an NP or CNS program within two years prior to application which included a 45 contact hour pharmacology course that meets Oregon's requirements. Please provide official transcript with Prescriptive Authority application; **or**
 - b) Completion of a 45 contact hour pharmacology course which meets Oregon's requirements within two years prior to application. Please provide official transcript or photocopy of certificate of completion with Prescriptive Authority application; **or**
 - c) Current prescriptive authority in a state or US jurisdiction, including a federal institution or facility **and**
 - A 30 contact hour course completed to obtain current prescriptive authority which is congruent with the specialty role sought **with**
 - An additional 15 hours of CE in pharmacological management congruent with the specialty role sought completed within the last two years. Please provide official transcript or photocopy of certification of completion with Prescriptive Authority application.

Pharmacotherapeutic Clinical Practicum

- 2) **Pharmacotherapeutic clinical practicum must be completed after the pharmacology course under direct supervision of a Medical Doctor (MD/DO), NP, or CNS with current Oregon prescriptive authority. I have met the clinical practicum requirement through one of the following:**
- a) Completion of a directly supervised clinical practicum of no less than 150 hours which includes differential diagnosis and applied pharmacological management of patients congruent with the specialty sought.
 - Completed as part of a CNS or NP academic program.
 - Completed as part of a practicum outside of original academic program. *Please provide completed Verification of Clinical Practicum in Pharmacological Management form with Prescriptive Authority application and supporting transcripts or CE documentation of completion.*
 - b) Proof of current prescriptive authority in another state, US jurisdiction, federal institution or facility with practice including use of prescriptive authority of at least 400 hours within the last two years.

Additional information

- Read the booklet titled, *Prescriptive Authority in Oregon for Nurse Practitioners and Clinical Nurse Specialists*. This booklet is also available on the OSBN website at: www.oregon.gov/OSBN/pdfs/publications/prescriptive_booklet.pdf The required confirmation statement postcard is also available as the last two pages of the booklet which can be printed out, signed and included with your application documents.
- If your pharmacology coursework is not clearly indicated in transcripts sent to OSBN, please provide a course description and documentation defining how you meet the Oregon requirement.
- Oregon does not accept integrated pharmacology.
- A list of approved pharmacology continuing education courses can be found on the OSBN website at www.oregon.gov/OSBN/pdfs/ApprovedPharmCourses.pdf OSBN will mail a list of approved pharmacology continuing education courses upon request.



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Prescriptive Authority Application Checklist

- Have a current Oregon Registered Nurse (RN) license.** If you do not have current Oregon RN licensure, ensure that the process is completed.
- Photocopies of your current RN, NP and/or CNS prescriptive authority license(s)** with the application if you are licensed in another state, if applicable.
- Complete the application for Prescriptive Authority.**
 - Read the booklet titled, *Prescriptive Authority in Oregon for Nurse Practitioners and Clinical Nurse Specialists*. This booklet is also available on the OSBN website at: www.oregon.gov/OSBN/pdfs/publications/prescriptive_booklet.pdf
 - Sign and return the confirmation statement postcard attesting knowledge of Oregon and federal pharmacy law. The required confirmation statement postcard is also available as the last two pages of the booklet which can be printed out, signed and included with your application documents.
 - Complete and sign the application. Applications received without a signature will not be accepted.
- Mail application(s) and non-refundable application fee(s) to OSBN for processing.** If you also need to apply for a Limited License for Prescriptive Authority Practicum, contact OSBN for the additional application.
- Mail request to your school(s) for an official, final transcript and/or attach photocopies of certificate(s) of completion showing satisfactory completion of required coursework.** The official transcript must be mailed directly from your NP or CNS degree program to OSBN. The transcript must be imprinted with an official seal, bear the appropriate registrar's signature and must show completion date and degree granted. A **Licensure Transcript Request** form is included with this application packet for your convenience.



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

Prescriptive Authority Application

For office use only

FEE OWED FOR THIS APPLICATION:

\$ 75.00

The above fee is non-refundable and applies only for this application for Prescriptive Authority. Checks should be made payable to the Oregon State Board of Nursing.

SECTION 1: LICENSE TYPE

For which license are you applying? [] CNS Initial \$75.00 fee [] NP adding Prescriptive Authority to CNS (No fee)
[] NP Initial \$75.00 fee [] NP adding additional specialty/category (No fee)

SECTION 2: NAME & ADDRESS

Last Name: _____
First Name: _____ Middle Name: _____
Former/Maiden Name(s): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____
Home Telephone: (____) _____ - _____ Unlisted? [] Yes [] No
Work Telephone: (____) _____ - _____

SECTION 3: PERSONAL IDENTIFIERS

Date of Birth (mm/dd/yyyy): ____/____/____ Country of Birth: _____
City of Birth: _____ State of Birth: _____ Gender: [] Female [] Male
Ethnicity: [] African American/Black [] Caucasian/White
[] American Indian/Alaska Native [] Hispanic or Latino
[] Asian (e.g., Filipino, Japanese, Chinese, etc.) [] Native Hawaiian/Other Pacific Islander
[] Multi-ethnic or racial background

Social Security Number: _____ - _____ - _____

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

Consultant's Approval _____ Date _____
RN License # _____ Adv Prx License # _____

SECTION 4: PRACTICE INFORMATION

Please provide the primary location you will be utilizing your prescriptive authority in Oregon. If there will be additional locations of practice, please attach a separate piece of paper that includes the additional location information.

_____	(_____) _____ - _____
Primary Practice Name	Telephone number

Address	
_____	_____
City	State Zip code

SECTION 5: FEDERAL DRUG REGISTRATION

Please complete the following section to provide information about the status of your DEA registration / number.

I have Prescriptive Privilege in another state. No Yes _____

State State State

I have a DEA number. No

Yes DEA number _____

Pending. I will send a photocopy of my DEA registration to the OSBN when I receive it.

Please mail a photocopy of your DEA registration to the OSBN or fax a photocopy of your DEA registration to (971)673-0684, Attention: Advanced Practice Consultant.

SECTION 6: CURRENT PRESCRIPTIVE AUTHORITY

If you have current unencumbered prescriptive authority in any state or US jurisdiction, including a US federal institution or facility and 400 hours utilizing prescriptive authority within the last 2 years, please check all the following that apply.

- Prescribing for individual patients
- Prescribing for populations
- Establishing and/or approving standing orders and protocols for drug therapy
- Active membership of a state, facility, or professional formulary committee which determines drug selection recommendations
- Investigator for drug studies
- Teaching pharmacology at the advanced nursing level
- Conducting and publishing research with a primary focus on patient management through drug therapy
- Expert consultation regarding prescribing standards and practice
- Other (Please specify) _____

NOTICE: You must read the Prescriptive Authority in Oregon booklet and then sign and return the enclosed signature postcard with your Prescriptive Authority application.

SECTION 7: CERTIFYING STATEMENT

I hereby certify that I have read this application, that I have personally completed this form, and that the information provided on this form is true, correct, and complete to the best of my knowledge. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of licensure/certification. I am aware that the Oregon State Board of Nursing will conduct a criminal records check through the Law Enforcement Data System (LEDS). I am aware that if any disciplinary action is taken against my license, my social security number will be reported to the federal Health Care Integrity and Protection Data Bank.

Printed Name: _____ Date (mm/dd/yyyy): _____ / _____ / _____

Signature: _____

(Application will not be processed without signature.)