



Oregon State Board of Nursing

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

Licensure Renewal / Reactivation Application Instructions

Attention

- Please allow a minimum of 10 business days to process paper applications.
- You may not work in Oregon as a Nurse without a valid Oregon Nursing license / certificate.
- **Please note:** On-line renewal is now available! Visit our website at www.oregon.gov/OSBN to renew your license / certificate.

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

Fees

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**.

License(s)	On-time Renewal	Late Renewal	Reactivation *
	Renewing before expiration date of license(s)	Renewing within 60 days after expiration date of license(s)	Renewing 61 or more days after expiration date of license(s)
LPN or RN	\$145	\$157	\$160
RN with CRNA	\$200	\$224	\$227
RN with CNS (without Prescriptive Authority)	\$220	\$244	\$247
RN with CNS-PP (with Prescriptive Authority)	\$250	\$274	\$277
RN with NP-PP (First category)	\$250	\$274	\$277
More than one Nurse Practitioner category?	If you hold more than one NP category, add \$50 for each additional category.	If you hold more than one NP category, add \$62 for each additional category.	If you hold more than one NP category, add \$62 for each additional category.
			Fingerprint processing * \$52

* **Oregon Licensure Reactivation applicants must complete a national fingerprint based Criminal Background Check.** Contact the OSBN by sending an email to osbn.fingerprintinginfo@state.or.us or call 971-673-0685 for more information.

Pain Management Continuing Education Requirement

According to Oregon law passed in 2001, nurses and other health care providers must receive seven hours of pain management related continuing education within 24 months of their first renewal after January 1, 2006. One of the seven hours must be a course offered on-line at (www.oregon.gov/DHS/pain/training.shtml). The remaining six hours can be your choice of CE courses that are accredited by an established accrediting body (such as another board of nursing or a national organization / association) for Continuing Nursing Education (CNE) or Continuing Medical Education (CME).



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Licensure Renewal / Reactivation Checklist

ALL LICENSE TYPES

Complete the Licensure Renewal Application.

- Use your legal name on the application and all forms.
- Read all instructions and complete all questions on the application. If clarity is necessary, please attach written explanation on a separate sheet of paper.
- Remember to sign the application. Applications received without a signature will not be processed.
- Please reference the Fee table included in the instructions.
- Please send check or money orders payable to the Oregon State Board of Nursing. Fees paid to the Oregon State Board of Nursing are **not refundable**.

REACTIVATION APPLICATIONS

- Provide work history for the last five years.
- Provide license verification for the state where you are currently licensed or the state in which you last practiced nursing. Go to www.NURSYS.com for more information.
- Call our office to obtain a fingerprinting packet.

ADVANCED PRACTICE APPLICATIONS

- If you are a Nurse Practitioner (NP-PP) or Clinical Nurse Specialist with Prescriptive Privilege (CNS-PP), remember to list your DEA number, if you have one.
- If you are a Nurse Practitioner (NP-PP), Clinical Nurse Specialist with Prescriptive Privilege (CNS-PP) or Clinical Nurse Specialist (CNS), remember to attach your Advanced Practice Continuing Education information to your Licensure Renewal application.
- If you are a Certified Registered Nurse Anesthetist (CRNA), remember to attach a copy of your current national CCNA certification or re-certification card.



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

Licensure 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. See the Fee table in the instructions for this application for details. Fees are not refundable.

Empty box for License Number

License Number

SECTION 1: LICENSE(S) AND/OR CERTIFICATE(S) BEING RENEWED OR REACTIVATED

- Check one option: I am renewing my license(s) on time. I am renewing my license(s) within 60 days after the expiration date. I am reactivating my license(s) 61 or more days after the expiration date.

LICENSE TYPE : (Check all that apply. Advanced practice nurses also should check RN.)

- RN LPN CRNA CNS Prescriptive Authority
ACNP ANP CHNP FNP GNP NNP NMNP PNP PMHNP WHCNP

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: _____

Email: _____ Country: _____

Home Telephone: (____) ____ - ____ Work Telephone: (____) ____ - ____
Unlisted? Yes No Contact preference (E-mail, mail, telephone): _____

(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 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.

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 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: NURSING PRACTICE

- Please complete the requested information for your nursing practice since the last renewal of your licensure. You will be contacted if additional information is needed.
- The information you provide regarding practice hours will be subject to random audits.
- Print as many copies of this section as needed to document your practice history since your last renewal.
- Please begin with your most recent employer and work backwards in time.

Date that you last practiced nursing (mm/dd/yyyy) : ___/___/_____

_____				(____)____-_____	
Company Name				Telephone number	
_____		_____		_____	_____
Address		License Number		State	Country
_____		_____	_____	_____	
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

_____				(____)____-_____	
Company Name				Telephone number	
_____		_____		_____	_____
Address		License Number		State	Country
_____		_____	_____	_____	
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

_____				(____)____-_____	
Company Name				Telephone number	
_____		_____		_____	_____
Address		License Number		State	Country
_____		_____	_____	_____	
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

_____				(____)____-_____	
Company Name				Telephone number	
_____		_____		_____	_____
Address		License Number		State	Country
_____		_____	_____	_____	
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

SECTION 5 CONTINUED: NURSING PRACTICE**LPN - RN - CLINICAL NURSE SPECIALIST (CNS) - NURSE PRACTITIONER (NP)**

1. I have been licensed / certified in Oregon for: Less than 1 year 1 - 2 years More than 2 years
2. I have practiced 960 hours as either a RN, or LPN or CNS(only), or Nurse Practitioner (only) in the last five years
(LPN practice does not count toward RN renewal; RN/LPN practice does not count toward NP or CNS renewal): Yes No
If No, have you graduated from an RN, LPN or CNS program within the last five years? Yes No
If No, have you practiced at least 192 hours as a Nurse Practitioner (only) and graduated from a Nurse Practitioner program within the last two years? Yes No
If No, have you graduated from a Nurse Practitioner program within the last year? Yes No
If No, have you completed a re-entry program within the last two years? Yes No
3. I have completed the mandatory 7 hours of pain management continuing education. Yes No

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

1. I have been licensed / certified in Oregon for: Less than 1 year 1 - 2 years More than 2 years
2. I have practiced 850 hours as a CRNA (only) in the last two years: Yes No
If No, have you graduated from an nurse anesthesia or re-entry program within the last two years? Yes No
3. I have completed the mandatory 7 hours of pain management continuing education. Yes No

SECTION 6: REACTIVATIONS (RENEWING 61 OR MORE DAYS PAST THE EXPIRATION DATE)

If you have been previously licensed in Oregon, and are renewing 61 or more days past the expiration date of your nursing licensure, you must Reactivate your license(s). **As of January 1, 2008 Licensure Reactivation applicants are required to provide fingerprints as part of the application process. If you do not have the Fingerprint Information packet, contact the Oregon State Board of Nursing (OSBN) by email at osbn.fingerprintinginfo@state.or.us or call 971-673-0685 for more information.**

To be eligible to reactivate your Oregon Nursing license you must have practiced as a LPN, RN, CNS or NP for at least 960 hours in the last five years; or as a CRNA for at least 850 hours in the last two years. Graduation from an approved nursing program within the last five years satisfies this requirement. Advanced Practice Nurses must also fulfill their continuing education requirements, covered in Section 11 of this application. *If you cannot meet these eligibility requirements, please contact the OSBN office at 971-673-0685 for information on other options.*

LPNs and RNs who practiced in another state after the last expiration date of their Oregon license must request a verification of their nursing licensure from the state where they currently practice (or most currently practiced) nursing. Some states issue their own verifications, however most states are linked to NURSYS, an on-line national verification system used by most Boards of Nursing across the country.

I have practiced in another state since my Oregon Nursing license expired. Yes No

If **YES**: In addition to completing this application, you must provide OSBN with verification of licensure from the state you last practiced in. Follow the directions on the website at www.nursys.com for states participating in the NURSYS verification system. If the state where you most recently practiced nursing is not listed with NURSYS, follow the instructions on the Verification of Current Licensure form.

If **NO**: If you haven't practiced in another state after the expiration date of your Oregon nursing license(s) and are simply very late in renewing, you should complete only this application and send it and the appropriate fee to the OSBN office.

SECTION 7: ADVANCED PRACTICE NURSES**NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS WITH PRESCRIPTIVE AUTHORITY (NP-PP OR CNS-PP)****1. Prescriptive privilege information**

I meet the continued prescribing requirements through (Select one):

- Completion of 45 hour pharmacology course within past two years.
- 400 hours in the past two years of utilizing prescriptive authority which meets the Oregon requirements of prescribing.
Current prescribing standards are located on the OSBN website at www.oregon.gov/OSBN/pdfs/policies/prescribing.pdf
- My DEA number is : _____ Expiration date (mm/dd/yyyy) : ____/____/____
- My registration with the DEA is pending. I will notify the OSBN once I receive it.
- I decline DEA registration at this time.

2. I have dispensing privileges and my practice population meets the requirements set forth in OAR 851-056-0020.

- Not Applicable; I do not have dispensing privileges.
- Yes, however I do not wish to renew my dispensing privileges.
- Yes and I wish to renew my dispensing privileges.

3. Please provide the primary location where you utilize your authority to prescribe and / or dispense prescription drugs in Oregon. If there are additional locations of practice for dispensing or prescribing, please attach a separate piece of paper that includes the additional location information. Include hours prescribing at this employer location.

_____		(____)____-_____	
Primary Practice Name		Telephone number	
_____		<input type="checkbox"/> Dispensing?	
Address		<input type="checkbox"/> Prescribing?	
_____	_____	_____	_____
City	State	Zip code	Hours Prescribing

4. To meet the continuing education requirement, I have :

- Completed 100 or more contact hours of continuing education in the last two years which includes at least 15 hours of pharmacotherapeutic content. *Note: 50% of the continuing education contact hours must be Structured accredited courses.*
- Graduated from a NP or CNS program less than two years ago (mm/dd/yyyy) ____/____/____ and completed _____ contact hours of continuing education.
- Neither of the above apply (Explain on a separate sheet of paper).

CLINICAL NURSE SPECIALISTS WITHOUT PRESCRIPTIVE AUTHORITY (CNS)**1. To meet the continuing education requirement, I have :**

- Completed 40 or more contact hours of continuing education in the last two years.
- Graduated from a CNS program less than 2 years ago on (mm/dd/yyyy) ____/____/____ and completed _____ contact hours of continuing education. *Note: 50% of the continuing education contact hours must be Structured accredited courses.*
- Neither of the above apply (Explain on a separate sheet of paper).

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)**1. To meet the continuing education requirement, I have :**

- Completed 40 or more contact hours of continuing education approved by the American Association of Nurse Anesthetists in the last two years.
- Graduated from a CRNA program less than two years ago on (mm/dd/yyyy) ____/____/____ and completed _____ contact hours of continuing education.
- Neither of the above apply (Explain on a separate sheet of paper.)

2. Do you hold current certification (or re-certification) from the Council on Certification of Nurse Anesthetists (CCNA)?

- Yes** (Attach copy of current certification or re-certification card.) **No** (Explain on separate sheet of paper.)

SECTION 8: 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"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Spanish
			<input type="checkbox"/> Vietnamese
			<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"/> Ambulatory Surgical Center	<input type="checkbox"/> Hospital	<input type="checkbox"/> Occupational Health Clinic
	<input type="checkbox"/> Ambulatory Urgent / Emergency	<input type="checkbox"/> Insurance / Managed Care	<input type="checkbox"/> Office / Clinic
	<input type="checkbox"/> Assisted-Living	<input type="checkbox"/> Military	<input type="checkbox"/> Other
	<input type="checkbox"/> Community Based Group Home	<input type="checkbox"/> None	<input type="checkbox"/> Primary Care
	<input type="checkbox"/> Drug / Alcohol Center	<input type="checkbox"/> Nursing Education Program	<input type="checkbox"/> Private Duty
			<input type="checkbox"/> Public / Community Health
			<input type="checkbox"/> Residential Care Facility
			<input type="checkbox"/> Retired
			<input type="checkbox"/> School Health
			<input type="checkbox"/> State or Federal Agency
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:

- Maintain my practice as is. Increase my practice hours. Move out of state.
 Significantly reduce practice (patient care) hours. Move my practice to another Oregon location. Retire.
 None of the above.

When do you plan to retire?

- Already retired. Within the next 5 years. Within the next 6-10 years.
 More than 10 years from now. Don't know / Uncertain.

SECTION 9: 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). 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 Practice History

Please type or print clearly using black ink on the front and back

- If you worked for a multi-state corporation or agency, list location of your assignment(s), not the state where the corporate headquarters is located.
- List your nursing practice history, for the most recent five years in which you practiced nursing.
- Complete a separate section for each nursing position in the last or most recent five years.
- If you volunteered or did private duty, give the name and address of the registry or individual.

Mark here if you are a recent Nursing graduate and do not have any Nursing practice history.

Last Name	First Name	Social Security Number -- --
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Indicate your practice hours **by calendar year for the most recent six years** you have practiced. (*Do not include hours you were on vacation, sick leave or leave of absence.*) For example, if you last practiced in 2005, complete the Practice Summary Table for years 2005, 2004, 2003, 2002, 2001 and 2000.

Practice Summary Table	Calendar Year Practiced	Total Hours Practiced Each Year	Nursing License(s) Used for Practice
1 st year (<i>most recent</i>)			
2 nd year			
3 rd year			
4 th year			
5 th year			
6 th year			

Most recent employer - Not agency (<i>If none, indicate NONE</i>)		Area Code ()	Telephone Number
Employer Address		City	State Zip Code
Start Date (mm/dd/yyyy)		If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice			
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (<i>Less than 36 hours a week</i>)			
Position Held		Primary Duties as a Nurse (<i>Describe briefly</i>)	

Employer Name - Not agency (If none, indicate NONE)		Area Code ()	Telephone Number
Employer Address		City	State Zip Code
Start Date (mm/dd/yyyy)		If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice			
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)			
Position Held		Primary Duties as a Nurse (Describe briefly)	

Employer Name - Not agency (If none, indicate NONE)		Area Code ()	Telephone Number
Employer Address		City	State Zip Code
Start Date (mm/dd/yyyy)		If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice			
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)			
Position Held		Primary Duties as a Nurse (Describe briefly)	

Employer Name - Not agency (If none, indicate NONE)		Area Code ()	Telephone Number
Employer Address		City	State Zip Code
Start Date (mm/dd/yyyy)		If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice			
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)			
Position Held		Primary Duties as a Nurse (Describe briefly)	

Employer Name - Not agency (If none, indicate NONE)		Area Code ()	Telephone Number
Employer Address		City	State Zip Code
Start Date (mm/dd/yyyy)		If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Paid Nursing Practice or <input type="checkbox"/> Volunteer Nursing Practice			
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)			
Position Held		Primary Duties as a Nurse (Describe briefly)	