



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

# Oregon Application for Initial Nurse Practitioner License

## Section 1: Application Information

- **Education:** Contact your school to request official sealed transcripts be sent directly to OSBN, or if your school subscribes to a national document transfer network, you may request the service to send official electronic transcripts to OSBN at: [osbn.transcripts@state.or.us](mailto:osbn.transcripts@state.or.us).
- **Oregon RN License:** An applicant for NP licensure must also hold an active unencumbered Oregon RN license. The RN application can be submitted for processing at the same time as the NP.
- **APRN Prescriptive Authority:** Per Oregon Administrative Rule (OAR) 851-056-0006 an applicant for nurse practitioner licensure must also qualify, apply for, and be issued prescriptive authority. There is a separate application and fee required, the form has been included in this packet for your convenience.
- **Applications:** Submit both original NP and Prescriptive Authority applications- copies are not accepted. Mail application documents and check or money order to OSBN at: 17938 SW Upper Boones Ferry Rd, Portland OR 97224.
- **Fingerprinting:** OSBN requires a national fingerprint-based criminal background check to apply for and obtain licensure/certification in Oregon. Applicants will be charged a separate fee of \$64.50 by Fieldprint Inc an independent organization contracted by the State of Oregon to provide electronic fingerprinting services. **This fee is payable only to Fieldprint Inc** while registering on their website to schedule an electronic fingerprinting appointment.
- **Check Your Email:** Once your application and full payment are received, you will be sent an email to the address you provided on your application. It gives you the instructions you need in order to register with Fieldprint Inc. to schedule and pay for your fingerprinting appointment.
- **Application Status:** You may track the progress of your applications using the Application Status Wizard available on the OSBN website at: [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN). The status of a required item is updated online as it is processed by OSBN staff.

## Section 2: Application Fees- ALL OSBN FEES ARE NON-REFUNDABLE

Application Type	Fee
Nurse Practitioner Application Valid for one year from date of receipt of application and full payment.	<b>\$150</b>

## Section 3: NP Education

Applicants for NP licensure in Oregon must hold a minimum of a Master’s Degree in Nursing from an accredited graduate-level program if completed after January 1 1986. The qualifying program scope and population focus must align with the NP specialty for which the application is submitted. An acceptable official transcript (US grads) or a credential equivalency evaluation (non-US nursing grads) sent directly to OSBN meets this application requirement.

## Section 4: NP Practice History

The practice requirement must be met in one of the following ways:

- Completion of qualifying NP program within the past one year; OR
- Completion of qualifying NP program within the past two years and a minimum of 192 hours of NP practice; OR
- 960 NP practice hours completed in the last 5 years from the date of application.

## Section 5: NP National Certification

Valid unencumbered NP national certification issued by a nationally accrediting body is required for Oregon certification. The NP population of your national certification must align with the NP specialty you are applying for. Contact your certifying body to request verification of your certification be sent directly to OSBN at [osbn.licenseverifications@state.or.us](mailto:osbn.licenseverifications@state.or.us). The verification must include the NP specialty, your certification number, and the expiration date. **Copies are not accepted to meet the requirement.**

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



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# Oregon Application for Initial Nurse Practitioner License

**IMPORTANT:** Faxed or emailed applications are not accepted. You may fill out the form electronically then print it out to sign and mail to OSBN. This application is valid for one year from date of receipt and will become null and void upon expiration.

## Section 1: NP Specialty

Select the specialty you are applying for:

## Section 2: Name and Address Information

Last Name:		First Name:	
Middle Name:		Former Name(s):	
Address:		Country:	
City:	State:	Zip:	
Primary Phone:	Secondary Phone:	Email: (required)	
<b>NOTE: OSBN uses the email address on file for all application and licensing renewal notifications. It is your responsibility to keep information on file current with OSBN to ensure receipt.</b>			

## Section 3: Personal Identifiers

Gender: Female      Male      Other/Non-Binary	Date of Birth:
<b>Required:</b> US Social Security Number	<b>ATTENTION: Per ORS 25.785, applicants must provide a US SSN, US Work Visa, US Taxpayer ID, or other current federal government form authorizing you to work in the US.</b> Information provided will be disclosed to entities and used for the purposes listed in OAR 851-001-0030 (2). Refusal to provide your SSN/ Visa/work documents will result in denial of licensure/certification. This denial will be reported to the National Practitioner Databank, as authorized by 42USC Section 666(a) (13). If you are currently working on a US Visa (H1B, I-766 or other current federal government form authorizing you to work in the US), please submit copies of your passport and the Visa along with this application. If you are attending school on an F1 Visa, please provide a copy of the I-94 and I-20 signed by the designated school authority.

## Section 4: Current State NP Licensure

List the state/US jurisdiction and the corresponding NP license you are using for current or most recent NP practice. Leave blank if you are a new graduate and have not yet held an NP license.

State/US Jurisdiction:

NP License Number:

## Section 5: National Certification

Contact your national accrediting body to have primary source verification of your active national certification sent to the OSBN email address: [osbn.licenseverifications@state.or.us](mailto:osbn.licenseverifications@state.or.us).

National  
Certifying Body:

Certification Number:

Expiration Date:

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

OSBN USE ONLY - Application Expiration Date

OSBN USE ONLY - Additional Information  
App Exp. \_\_\_\_\_  
CBC \_\_\_\_\_  
NP Transcript \_\_\_\_\_  
National Cert. \_\_\_\_\_  
Practice Hours & NP State License \_\_\_\_\_

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

**Section 6a: Instructions for Disclosure Section**

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

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

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

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

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

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

**Question 3: Criminal History**

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

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

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

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

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

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

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

**Question 7: Credentialing Privileges**

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

**Question 8: Malpractice**

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

## Section 6b: Disclosure

Before answering the questions below, please review the instructions for information to provide regarding any disclosure(s). Providing false, misleading, or incomplete information is considered falsifying an application and is grounds for denial of your application or discipline on your license/certification. I understand I must provide the Oregon State Board of Nursing (OSBN) with any updates to information required in this application while it is pending.

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

Applicant Last Name

First Name:

**Section 7: NP Education Program**

List the nurse practitioner program you completed that qualifies you for licensure in the NP specialty you selected.

Name of School:		City:	
Degree/Certificate:		State:	
NP Specialty:	Graduation Date: (mm/dd/yy)		
Full Name On Transcript:			

**Section 8: NP Practice History**

Leave section blank if you graduated less than a year ago and have not yet practiced as an NP. Add separate sheet of paper if needed.

Company Name:		Phone:	Country:
Site Address:		City:	Zip Code:
Position Title:		License Number:	Licensing State:
Still Employed: Yes No	Paid Practice: Yes No	Start Date (mm/dd/yy):	End Date (mm/dd/yy):
Total number of practice hours in this position (required):			

**Section 9: Authorization**

I understand I have a duty to provide the Oregon State Board of Nursing with any updates to information required in this application while it is pending. I hereby certify that I have read this application, and that the information provided is true and correct. I have personally completed this application. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or discipline of license/certification. I am aware that the Oregon State Board of Nursing will conduct criminal records checks through the Oregon Law Enforcement Data System (LEDS) and the Federal Bureau of Investigation (FBI).

I do not want my name and address shared with non-state agencies or for non-public health planning purposes. I understand this does not apply to requests made to OSBN for public information as authorized by ORS 192.420

Applicant Signature:	Date: (mm/dd/yy)
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# Oregon Application for APRN Prescriptive Authority

## Section 1: Application Information

- **Oregon APRN:** To submit an application for advanced practice prescriptive authority, you must also be currently applying for an initial Oregon NP, CRNA, or CNS at the same time, OR you already have an existing Oregon NP/CRNA/CNS, and are applying to *ADD* prescriptive authority to that license.
- **APRN & PP Applications:** Submit the original applications – copies are not accepted. Applications for initial NP, CRNA, or CNS licensure, AND the application for APRN Prescriptive Authority, including all applicable fees, must be submitted together.
- **OSBN Mailing Address:** Mail application documents and check or money order to OSBN at: 17938 SW Upper Boones Ferry Rd, Portland OR 97224.
- **Application Status:** You may track the progress of your application using the Application Status Wizard, available on the OSBN website at <https://osbn.oregon.gov/OSBNAppStatus/Search.aspx>

## Section 2: Application Fees- ALL OSBN FEES ARE NON-REFUNDABLE.

Application Type	Fee
APRN Prescriptive Authority for NP, CRNA, or CNS	<b>\$75</b>

## Section 3: Education Requirement

You must have completed graduate-level *stand-alone* (content was not combined with other topics into one course) nursing courses in **physical assessment, pathophysiology and pharmacology**, within your qualifying advanced practice nursing education program, or via continuing education (CE) credits completed.

**NOTE:** Course content for any one of the above components listed that was combined with other various topics into one class/course, is not acceptable to meet this requirement. The qualifying graduate-level pharmacology course must be equal to at least 45 contact hours of course content. Courses are verified as acceptable upon receipt of your official transcripts or CE certificates of completion.

## Section 4: Practice Requirement

You must meet the requirement for completion of clinical education in patient management in one of the following ways:

1. Completion of a 150-clock hour supervised academic clinical practicum that included differential diagnosis and applied pharmacological management of patients, congruent with my specialty role. **OR**
2. Current prescriptive authority in another U.S. state or jurisdiction AND 150 hours or more in the last 2 years of utilizing applied pharmacological management of patients, congruent with my specialty role. **OR**
3. 150 hours of clinical expertise in current practice that included differential diagnosis and applied pharmacological management of patients, and is congruent with my specialty role. **NOTE:** The practice hours must have been validated by a licensed independent prescribing practitioner, whom then completed and signed the OSBN form [APRN Pharmacological Management Evaluation Form Part B](#) LIC-204B as authorization. The signed form must be submitted with this application process. **OR**
4. None of the above. However, you completed 45 contact hours of APRN-level pharmacological continuing education within the last 2 years prior to application to satisfy the requirement. Include copies of your certificates of completion with your application.

## Section 5: OSBN Handbook

Before submitting your application, read the **Prescriptive and Dispensing Authority in Oregon for Advanced Practice Registered Nurses** handbook that is available on the OSBN website at [https://www.oregon.gov/OSBN/Documents/Booklet\\_prescriptive\\_authority.pdf](https://www.oregon.gov/OSBN/Documents/Booklet_prescriptive_authority.pdf)

The booklet reviews laws and regulations regarding prescribing and dispensing authority in Oregon. **You must confirm in this application that you have read the handbook and understand the information included.**



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# Oregon Application for APRN Prescriptive Authority

**NOTE:** Faxed or emailed applications are not accepted. You may fill out the form electronically, print it out to sign and mail in with payment to OSBN. This application is valid for one year from the date of payment and will be null and void upon expiration.

**Section 1: Application Type-** Check the appropriate box for the type of advanced practice license you are applying for, OR if you are an active Oregon APRN applying to *add prescriptive authority to your existing license*, check the box below the drop-down selection.

I am an Oregon APRN applying to add prescriptive authority to my existing license.

## Section 2: Name and Address Information

Last Name:		First Name:	
Middle Name:		Former Name(s):	
Address:		Country:	
City:		State:	Zip:
Primary Phone:		Email: (required)	
<b>NOTE: OSBN uses the email address on file for all application and licensing renewal notifications. It is your responsibility to keep information on file current with OSBN to ensure receipt.</b>			

## Section 3: Personal Identifiers

Gender: Female Male Other/Non-Binary	Date of Birth:
<b>Required:</b> US Social Security Number	<b>ATTENTION: Per ORS 25.785, applicants must provide a US SSN, US Work Visa, US Taxpayer ID, or other current federal government form authorizing you to work in the US.</b> Information provided will be disclosed to entities and used for the purposes listed in OAR 851-001-0030 (2). Refusal to provide your SSN/Visa/work documents will result in denial of licensure/certification. This denial will be reported to the National Practitioner Databank, as authorized by 42USC Section 666(a) (13). If you are currently working on a US Visa (H1B, I-766 or other current federal government form authorizing you to work in the US), please submit copies of your passport and the Visa along with this application. If you are attending school on an F1 Visa, please provide a copy of the I-94 and I-20 signed by the designated school authority.

## Section 4: Practice Requirement

I meet the requirement of completion of clinical education in patient management through (select one):

Completion of a 150-clock hour supervised academic clinical practicum that included differential diagnosis and applied pharmacological management of patients, congruent with my specialty role.

Current prescriptive authority in another U.S. state or jurisdiction AND 150 hours or more in the last 2 years of utilizing applied pharmacological management of patients, congruent with my specialty role.

150 hours of clinical expertise in current practice that included differential diagnosis and applied pharmacological management of patients, and is congruent with my specialty role.

I do not meet the requirement through any of these options. I have completed 45 contact hours of APRN-level pharmacological continuing education within the last 2 years. I have included copies of my certificates of completion with my application.

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

OSBN USE ONLY- Application Expiration Date

OSBN USE ONLY- Additional Information

- 3 Ps
- PP Practice Requirement Met
- State License Verified

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

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

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

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

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

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

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

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

**Question 3: Criminal History**

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

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

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

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

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

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

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

**Question 7: Credentialing Privileges**

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

**Question 8: Malpractice**

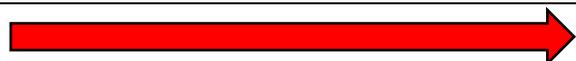
If you answered YES, provide a detailed written explanation. Describe the incidents that led to the action for notice or civil judgement against you. Provide documentation of the final determination.

## Section 5b: Disclosure

Before answering the questions below, please review the instructions for information to provide regarding any disclosure(s). Providing false, misleading, or incomplete information is considered falsifying an application and is grounds for denial of your application or discipline on your license/certification. I understand I must provide the Oregon State Board of Nursing (OSBN) with any updates to information required in this application while it is pending.

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

Application Continued on Next Page



**Section 6: Oregon Handbook on Prescriptive and Dispensing**

Indicate below the primary location you will be utilizing your prescriptive authority in Oregon.

Check here if you are currently seeking employment in Oregon, or for none at this time.

Business Name:		Telephone:	
Site Address:	City:	State:	Zip:

**Section 7: Oregon Handbook on Prescriptive and Dispensing**

I have read the handbook *Prescriptive and Dispensing Authority in Oregon for Advanced Practice Registered Nurses* that is available on the OSBN website at <http://www.oregon.gov/OSBN> and will comply with regulations regarding advanced practice registered nurses who prescribe and dispense prescription drugs in Oregon.

**Section 8: Authorization**

I understand I have a duty to provide the Oregon State Board of Nursing with any updates to information required in this application while it is pending. I hereby certify that I have read this application, and that the information provided is true and correct. I have personally completed this application. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or discipline of license/certification. I am aware that the Oregon State Board of Nursing will conduct criminal records checks through the Oregon Law Enforcement Data System (LEDS) and the Federal Bureau of Investigation (FBI).

I do not want my name and address shared with non-state agencies or for non-public health planning purposes. I understand this does not apply to requests made to OSBN for public information as authorized by ORS 192.420.

Applicant Signature	Date: (mm/dd/yy)
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