



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
**ADVANCED PRACTICE REGISTERED
 NURSE APPLICATION**

MAILING ADDRESS:
 STATE BOARD OF NURSING
 PO BOX 656
 JEFFERSON CITY MO 65102-0656
 (573) 751-0073
 Email: nursingpractice@pr.mo.gov
 Website: http://pr.mo.gov/nursing.asp

EXPRESS MAIL ADDRESS
 3605 MISSOURI BOULEVARD
 JEFFERSON CITY, MO 65109

FOR OFFICE USE ONLY			
APPROVED	PROFESSION	EXPIRATION DATE	
PRE-LICENSE NUMBER	LICENSE NUMBER	LICENSE DATE	
TRANSCRIPT	NURSYS	BACKGROUND CHECK	
RN ANCHOR LICENSE			
<input type="checkbox"/> CHECK <input type="checkbox"/> CASH <input type="checkbox"/> M.O.		DEPOSIT DATE	

Place a check mark in the shaded area below for changes/notes on application. see section for clarification.

SECTION I - PROFILE INFORMATION — ALL APPLICANTS			
	1. FULL NAME (LAST, FIRST, MIDDLE, MAIDEN)	PREVIOUS OR OTHER NAME(S)	
2. PRIMARY RESIDENCE (WHERE YOU VOTE, PAY FEDERAL TAXES, OBTAIN A DRIVERS LICENSE) - PHYSICAL ADDRESS REQUIRED. PO BOXES ARE NOT ACCEPTABLE			
CITY	STATE	ZIP CODE	
MAILING ADDRESS (IF DIFFERENT THAN PRIMARY RESIDENCE)			
CITY	STATE	ZIP CODE	
3. DATE OF BIRTH MONTH DAY YEAR	PLACE OF BIRTH (CITY) (STATE) (COUNTY)	MOTHER'S MAIDEN NAME	
4. SOCIAL SECURITY NUMBER (MANDATORY, USED FOR IDENTIFICATION PURPOSES ONLY)	TELEPHONE NUMBER - PERSONAL	TELEPHONE NUMBER - WORK	
5. PERSONAL EMAIL ADDRESS - REQUIRED (PLEASE PRINT)			
ANCHOR RN LICENSE INFORMATION			
<input type="checkbox"/> Missouri Registered Nurse (RN) License - _____ <input type="checkbox"/> RN multistate privilege to practice from another Nurse Licensure Compact state - _____ <input type="checkbox"/> I am submitting a Missouri RN license application concurrent with this APRN application.			
*Primary State of residence means that State of a person's declared fixed permanent and principal home for legal purposes; domicile. The following items could be requested as proof of primary state of residence; driver's license, voter registration card, federal income tax return.			
Have you or an immediate family member ever served in the U.S. Armed Forces? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, would you like information about military-related services in Missouri? <input type="checkbox"/> YES <input type="checkbox"/> NO			
GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE			
RACE/ETHNIC GROUP <input type="checkbox"/> CAUCASIAN (WHITE) <input type="checkbox"/> AFRICAN-AMERICAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> OTHER (if other, please indicate) _____			
NATIONALITY <input type="checkbox"/> AMERICAN <input type="checkbox"/> FOREIGN (PLEASE INDICATE) _____			
LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FOREIGN (PLEASE INDICATE) _____			
CITIZENSHIP <input type="checkbox"/> UNITED STATES <input type="checkbox"/> FOREIGN (PLEASE INDICATE) _____			

CITIZENSHIP OR ALIEN STATUS DECLARATION

ARE YOU A CURRENT CITIZEN OF THE UNITED STATES?

 Yes

If yes, submit with your application legible copy of your proof of citizenship document from List A. See the "Missouri Statement of Citizenship & Alien Status" in the instructions for List A. Most often submitted is a photocopy of a birth certificate or US passport.

 No (If no, go to **ALIEN STATUS DECLARATION**)

TYPE OF DOCUMENT YOU ARE SUBMITTING (I.E. PASSPORT, BIRTH CERTIFICATE)

EXPIRATION DATE, IF ANY (MM/DD/YYYY)

ALIEN STATUS DECLARATION

To be completed by applicants who are not citizens or nationals of the United States. Please indicate alien status by checking the appropriate box. Submit a legible copy of the front and back of a document from List B. See the "Missouri Statement of Citizenship & Alien Status" in the instructions for List B.

"Qualified Alien" Status

- a. An alien lawfully admitted for permanent residence under the Immigration and Nationality Act (INA).
- b. An alien who is granted asylum under Section 208 of the INA.
- c. A refugee admitted to the United States under Section 207 of the INA.
- d. An alien paroled into the United States for at least one year under Section 212(d)(5) of the INA.
- e. An alien whose deportation is being withheld under section 243(h) of the INA.
- f. An alien granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
- g. An alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).
- h. An alien who has, or whose child or child's parent has been declared a "battered alien" or an alien subjected to extreme cruelty in the United States.

Nonimmigrant Status (8 U.S.C. § 1621(a)(2))

- i. A nonimmigrant under the Immigration and Nationality Act [8 U.S.C. § 1101 et seq.] Nonimmigrants are persons who have temporary status for a specific purpose. See U.S.C § 1101(a)(15).

Alien paroled into the United States for less than one year (8 U.S.C. § 1621 (a)(3))

- j. An alien paroled into the United States for less than one year under Section 212(d)(5) of the INA.

Other Person (8 U.S.C. § 1621 (c)(2)(A) and (C))

- k. A nonimmigrant whose visa for entry is related to employment as a nurse in the United States.
- l. a work authorized nonimmigrant or an alien lawfully admitted for permanent residence under the INA (8 U.S.C. §1101 et seq.) and for whom the United States has a reciprocal treaty with to pay benefits;
- m. A foreign national not physically present in the United States.

Otherwise Lawfully Present Section 208.009 RSMo

- n. A person not described in categories A-M who is otherwise lawfully present in the United States. PLEASE NOTE: The federal Personal Responsibility and Work Opportunity Reconciliation Act may make persons who fall into this category ineligible for licensure.

To establish alien status, submit with your application a legible copy of the documents from List B.

TYPE OF DOCUMENT YOU ARE SUBMITTING (I.E. PASSPORT, BIRTH CERTIFICATE)

EXPIRATION DATE, IF ANY (MM/DD/YYYY)

SECTION II – APRN CERTIFICATION HELD OR APPLIED FOR

NAME OF NATIONALLY RECOGNIZED CERTIFYING BODY	EXAMINATION DATE	CERTIFICATION NUMBER	CERTIFICATION EXPIRATION DATE

LICENSURE HISTORY - ATTACH ADDITIONAL SHEET IF NECESSARY

NAME OF STATE	TYPE OF LICENSE	LICENSE NUMBER	IS THIS LICENSE CURRENT/ACTIVE	DISCIPLINARY ACTION AGAINST LICENSE
ORIGINAL STATE/EXAMINING STATE	<input type="checkbox"/> RN <input type="checkbox"/> APRN <input type="checkbox"/> LPN		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER STATE	<input type="checkbox"/> RN <input type="checkbox"/> APRN <input type="checkbox"/> LPN		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER STATE	<input type="checkbox"/> RN <input type="checkbox"/> APRN <input type="checkbox"/> LPN		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER STATE	<input type="checkbox"/> RN <input type="checkbox"/> APRN <input type="checkbox"/> LPN		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER STATE	<input type="checkbox"/> RN <input type="checkbox"/> APRN <input type="checkbox"/> LPN		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION III – ADVANCED PRACTICE NURSE EDUCATION

NAME & ADDRESS OF ADVANCED PRACTICE PROGRAM	OFFICIAL DATE OF COMPLETION	OFFICIAL DESIGNATED MAJOR OR CLINICAL SPECIALTY	TYPE OF DEGREE AWARDED
			<input type="checkbox"/> Certificate <input type="checkbox"/> Masters/Nursing <input type="checkbox"/> PhD/Nursing <input type="checkbox"/> Other (Please explain) _____
			<input type="checkbox"/> Certificate <input type="checkbox"/> Masters/Nursing <input type="checkbox"/> PhD/Nursing <input type="checkbox"/> Other (Please explain) _____

SECTION IV - CLINICAL NURSING SPECIALTY AREA – ALL APPLICANTS

Indicate advanced practice registered nursing category and area of clinical nursing specialty for which you are applying.

Advanced Practice Registered Nurse Role and Population		
<input type="checkbox"/> Certified Nurse Midwife	Certified Nurse Practitioner <input type="checkbox"/> Family <input type="checkbox"/> Pediatric <input type="checkbox"/> Acute Care <input type="checkbox"/> Gerontological <input type="checkbox"/> Neonatal <input type="checkbox"/> Adult <input type="checkbox"/> Psychiatric <input type="checkbox"/> Adult <input type="checkbox"/> Child/Adult <input type="checkbox"/> Family <input type="checkbox"/> Women's Health <input type="checkbox"/> Other (Please explain on a separate sheet of paper.)	Certified Clinical Nurse Specialist <input type="checkbox"/> Adult <input type="checkbox"/> Acute Care <input type="checkbox"/> Women's Health <input type="checkbox"/> Other (Please explain on a separate sheet of paper.)
<input type="checkbox"/> Certified Registered Nurse Anesthetist		

APPLICATION HISTORY - LIST ANY STATES/TERRITORIES/COUNTRIES WHERE YOU APPLIED FOR A NURSING LICENSE BUT A LICENSE WAS NOT ISSUED. ATTACH ADDITIONAL PAGE(S) IF NECESSARY.			
NAME OF STATE/TERRITORY/COUNTRY	TYPE OF LICENSE	REASON NEVER LICENSED	
	<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> APRN	<input type="checkbox"/> Failed Exam <input type="checkbox"/> Denied a License <input type="checkbox"/> Did not meet licensure requirements <input type="checkbox"/> Restriction was going to be placed on license	<input type="checkbox"/> Required to participate in an alternative program <input type="checkbox"/> Withdrew Application <input type="checkbox"/> Changed plans - let application expire <input type="checkbox"/> Other:
	<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> APRN	<input type="checkbox"/> Failed Exam <input type="checkbox"/> Denied a License <input type="checkbox"/> Did not meet licensure requirements <input type="checkbox"/> Restriction was going to be placed on license	<input type="checkbox"/> Required to participate in an alternative program <input type="checkbox"/> Withdrew Application <input type="checkbox"/> Changed plans - let application expire <input type="checkbox"/> Other:
	<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> APRN	<input type="checkbox"/> Failed Exam <input type="checkbox"/> Denied a License <input type="checkbox"/> Did not meet licensure requirements <input type="checkbox"/> Restriction was going to be placed on license	<input type="checkbox"/> Required to participate in an alternative program <input type="checkbox"/> Withdrew Application <input type="checkbox"/> Changed plans - let application expire <input type="checkbox"/> Other:
SCREENING QUESTIONS			
ABSOLUTE AND COMPLETE CANDOR IS REQUIRED. IF YOU ARE IN DOUBT WHETHER OR NOT TO REPORT, YOU SHOULD REPORT IT.			
1.	Have you ever been denied a professional license, multistate license, certification, registration or permit? If yes, explain fully in a separate signed and dated statement to include the type of license, certification, registration or permit that was denied; the reason for denial and the name and address of the licensing agency. <input type="checkbox"/> YES <input type="checkbox"/> NO		
2.	Have you ever had any privilege to practice, professional license, certification, registration, or permit revoked, suspended, placed on probation, or otherwise subject to any type of disciplinary action? If yes, explain fully in a separate signed and dated statement to include the date the action was taken; the type of license, certification, registration or permit; an explanation of the charges leading to the action and the name and address of the licensing agency. <input type="checkbox"/> YES <input type="checkbox"/> NO		
3.	Are you currently a participant in a state board/designee monitoring program, including alternative to discipline, diversion or a peer assistance program, in any state other than Missouri? If yes, explain fully in a separate signed and dated statement to include the state, dates and reason for participation. <input type="checkbox"/> YES <input type="checkbox"/> NO		
4.	Are you presently being investigated or is any action pending against any professional license, certification, registration, or permit you hold? If yes, explain fully in a separate signed and dated statement to include dates, status, an explanation of the allegations and the name and address of the licensing agency. <input type="checkbox"/> YES <input type="checkbox"/> NO		
5.	Have you ever voluntarily surrendered or relinquished any professional license, certification, registration, or permit during or following an investigation? (This does not include failing to renew your license or allowing it to lapse for non-disciplinary reasons.) If yes, explain fully in a separate signed and dated statement to include date, an explanation of the allegations and the name and address of the licensing agency. <input type="checkbox"/> YES <input type="checkbox"/> NO		
6.	Have you ever been convicted, adjudged guilty by a court, pled guilty, pled nolo contendere or entered an Alford plea to any crime, whether or not sentence was imposed, excluding traffic violations? (This includes any crime where the disposition was suspended imposition of sentence (SIS), or a suspended execution of sentence (SES) or if you pled guilty but were placed in an alternative or diversion court including drug or DWI court.) If yes, explain fully in a separate signed and dated statement to include the location and date of the offense, the sentence by the court, and your explanation of the events that led to the crime. This is your opportunity to explain the situation to the Board. Court documents, which you need to provide, would consist of Information, Complaint or Indictment Sheet, the Judgment, Docket Sheet or other documents showing disposition of your case. This can also be referred to as the Order of Probation. The court MUST CERTIFY these court documents. <input type="checkbox"/> YES <input type="checkbox"/> NO		
7.	Have you ever been convicted, adjudged guilty by a court, pled guilty, pled nolo contendere or entered an Alford plea to any traffic offense resulting from or related to the use of drugs or alcohol, whether or not sentence was imposed? (This includes a disposition of a suspended imposition of sentence (SIS), suspended execution of sentence (SES) or placement in a post plea alternative or diversion court and includes municipal charges of driving while intoxicated, driving under the influence and/or driving with excessive blood alcohol content.) If yes, explain fully in a separate signed and dated statement to include the location and date of the offense, the sentence by the court, and your explanation of the events that led to the crime. This is your opportunity to explain the situation to the Board. Court documents, which you need to provide, would consist of Information, Complaint or Indictment Sheet, the Judgment, Docket Sheet or other documents showing disposition of your case. This can also be referred to as the Order of Probation. The court MUST CERTIFY these court documents. <input type="checkbox"/> YES <input type="checkbox"/> NO		
8.	Have you ever had a judgment rendered against you based upon fraud, misrepresentation, deception, or malpractice related to health care practice? If yes, explain fully in a separate signed and dated statement to include the date the judgment was rendered, an explanation of why the judgment was rendered and who rendered the judgment. <input type="checkbox"/> YES <input type="checkbox"/> NO		

SCREENING QUESTIONS CONTINUED

- 9. Do you have any condition or impairment, including a history of alcohol or substance use disorder, that is not being treated and currently interferes with your ability to practice in a competent and professional manner? **If yes, explain fully in a separate signed and dated statement to include a description of the condition or impairment and how it interferes with your ability to practice.** YES NO
- 10. Are you listed on any state or federal sexual offender registry? **If yes, explain fully in a separate signed and dated statement to include the date, reason for the placement and the name of the offender list and provide evidence of registration.** YES NO
- 11. Have you ever been placed on an employee disqualification list or other related restriction or finding pertaining to employment within a health-related profession issued by state or federal government or agency? **If yes, explain fully in a separate signed and dated statement to include the date you were placed on the list, how long your name is on the list and the name and address of the agency and provide evidence of placement, restriction, or finding.** YES NO

ATTESTATION

I am aware that all documents required for Advanced Practice Registered Nurse (APRN) license must be received in the Board office before my license may be issued. I hereby authorize the Board to release any of the documents needed for licensure to any third-party to the extent necessary to verify my eligibility for licensure in the State of Missouri. I am also aware it is my obligation, pursuant to Board regulations, to keep the Board informed of my current name and address. Application fees are non-refundable.

I realize I cannot practice nor use the title of an Advanced Practice Registered Nurse (APRN) without a current Missouri APRN license.

I hereby attest and affirm that the information contained in, or referenced by, this application is true, correct, complete and accurate and is not false or misleading. I understand that if this information is not true and correct I am subject to the penalties of filing false documents. Section 570.095, RSMo, filing false documents is a class D felony, unless the enhanced penalty provisions are applicable, in which case filing false documents is a class C felony.

APPLICANT'S SIGNATURE

DATE

APPLICATION IS VOID IF REQUIREMENTS FOR LICENSURE ARE NOT MET WITHIN ONE YEAR. YOU MUST HAVE A CURRENT MISSOURI RN LICENSE OR CURRENT MULTISTATE RN LICENSE FROM ANOTHER NURSE LICENSURE COMPACT STATE AND APRN NATIONAL CERTIFICATION TO QUALIFY FOR A MISSOURI APRN LICENSE.

FOR OFFICE USE ONLY - NOTES



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

PRINT LEGIBLY IN BLACK INK

I, _____, hereby authorize the MISSOURI STATE BOARD OF NURSING to release my social security number, in addition to any public information contained in my file at the MISSOURI STATE BOARD OF NURSING, regarding my licensure and application status as a Registered Professional Nurse/Advanced Practice Nurse to my national certifying body/bodies, _____ and/or their representatives, in order to facilitate interagency communication and retrieval of certification or recertification evidence.

A photostatic copy of this authorization will be considered as effective and valid as the original.

APPLICANT'S SIGNATURE

DATE

APPLICANT'S PRINTED NAME

APPLICANT'S SOCIAL SECURITY NUMBER