STATE OF MISSOURI
ADVANCED PRACTICE REGISTERED NURSE
APPLICATION INSTRUCTIONS

To quality for Advanced Practice Recognition in the State of Missouri, you must have a current Missouri Registered Nurse (RN) license or (effective June 1, 2010) be practicing on a privilege to practice from another Compact State*.

FOR INITIAL APPLICATION

General Instruction of Completing APRN Application:

- Complete the entire application in **black ink** and in your own handwriting.
- Sign the application in the presence of a notary public and have it notarized.

Send the following items to the Missouri State Board of Nursing Office:

- Completed, signed and notarized application.
- $150 Fee – Make check or money order payable to Missouri State Board of Nursing (Fee is Non-refundable)
- Copy of current certification card with expiration date.

Send the following item to your Certifying Body:

- Send *Consent to Release Certification Information Form* to your Certifying Body. A list of credentialing bodies accepted by the Missouri State Board of Nursing may be found at: *http://pr.mo.gov/nursing.asp*

- IMPORTANT INFORMATION!
  YOU ARE NOT RECOGNIZED BY THE STATE OF MISSOURI UNTIL THE BOARD OF NURSING RECEIVES A COPY OF YOUR CURRENT CERTIFICATION CARD. WITHOUT THIS RECOGNITION YOU ARE NOT PERMITTED NOR RECOGNIZED TO WORK AS AN APRN IN THE STATE OF MISSOURI.

To qualify as a Graduate Advanced Practice Nurse, the start date of your test window must be within 4 months of graduation.

FOR GRADUATION RECOGNITION

What I need to send to my Certifying Body from Missouri?

- Send the *Consent to Release Certification Information Form* to your certifying body. A list of credentialing bodies accepted by the Missouri State Board of Nursing may be found at: *http://pr.mo.gov/nursing.asp*

What I need to send to the Missouri State Board of Nursing, if I am requesting Graduate Status Recognition?

- Documents required from your school and certifying body.
  - Request your *official final* transcript from your Graduate Program and have it sent to the Board directly from their office to the Missouri State Board of Nursing Office showing the Graduate Degree awarded.

  - Copy of the eligibility to test notice/letter from your certifying body.

- A signed confirmation statement indicating the date you have scheduled to take the *first available* national certifying examination.

- Complete application as indicated above. Send a completed, signed and *notarized* application and the $150 fee to the Missouri State Board of Nursing.

IMPORTANT NOTE:

- Within five (5) business days of receipt of your exam results, you need to send a copy of your results; (pass or fail) to the Missouri State Board of Nursing. If you fail the exam, your Graduate Recognition ends immediately upon the receipt of those results.

FOR CONTINUED RECOGNITION:

- Be aware of the expiration date of your RN license. Missouri RN licenses expire on April 30th of odd years. If you are licensed in another Compact State, make sure your RN license stays current.
- Make sure your certification with your certifying body stays current. It is your responsibility to notify the State Board of Nursing when you renew that certification.
- Notify the Missouri State Board of Nursing of any change of address within a two week period.
- Please view the website at: *http//:pr.mo.gov/nursing.asp* to ensure you are practicing in compliance with the Missouri law and also to verify your Advanced Practice Document of Recognition.

*If you are coming to Missouri from a Compact State, you will have to have a criminal background check completed:

- You must contact L-1 Enrollment Services at 866-522-7067 or www.llenrollment.com to schedule an appointment and then submit a receipt from L-1 Enrollment Services substantiating proof of fingerprinting with your application.
- You will need to provide L-1 Enrollment Services with the Missouri ORI number MO920100Z. You will pay a fee directly to L-1 Enrollment Services for this service.

NOTE: APRNs in Missouri must have a Collaborative Practice Agreement to provide health services that include delegated medical acts.

For additional assistance contact the Missouri State Board of Nursing Office's Advanced Practice Department at 573-751-0073.

Revised 05/2010

MAILING ADDRESS:
STATE BOARD OF NURSING
PO BOX 656
JEFFERSON CITY MO 65102-0656
(573) 751-0681
Email: nursing@pr.mo.gov
Website: http://pr.mo.gov/nursing.asp

DELIVERY ADDRESS
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

ADVANCED PRACTICE REGISTERED NURSE APPLICATION

FOR OFFICE USE ONLY

APPROVED	APP DATE	DENIED	CRT
GRAD APP	GRAD APP DATE	GRAD EXP	GRAD CRT
CASH	MO	CHECK	DEPOSITED

SEE INSTRUCTIONS LETTER BEFORE COMPLETING THIS APPLICATION

APPLICATION FEE IS NON-REFUNDABLE. APPLICATION IS VOID IF REQUIREMENTS FOR RECOGNITION ARE NOT MET WITHIN ONE YEAR YOU MUST HAVE A CURRENT RN LICENSE FROM EITHER MISSOURI OR ANOTHER COMPACT STATE IN ORDER TO BE RECOGNIZED AS AN APRN IN MISSOURI.

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) STREET OR PO BOX

CITY | STATE | ZIP CODE

3. DATE OF BIRTH — MONTH | DAY | YEAR

PLACE OF BIRTH (CITY) (STATE) (COUNTY)

MOTHER'S MAIDEN LAST NAME

4. **SOCIAL SECURITY NUMBER (MANDATORY, USED FOR IDENTIFICATION PURPOSES ONLY)

TELEPHONE NUMBER - HOME ( )

TELEPHONE NUMBER - WORK ( )

5. INTERNET E-MAIL ADDRESS (OPTIONAL-PLEASE PRINT)

FAX NUMBER (OPTIONAL)

6. MISSOURI REGISTERED PROFESSIONAL NURSE LICENSE NUMBER ▶

OR

*STATE OF RESIDENCE MULTI-STATE LICENSE NUMBER

7. ARE YOU CURRENTLY OR HAVE YOU EVER PRACTICED, REPRESENTED, OR DESIGNATED YOURSELF AS A NURSE ANESTHETIST, NURSE MIDWIFE, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST IN MISSOURI?

☐ NO ☐ YES

IF YES, PROVIDE A NOTARIZED STATEMENT INDICATING TITLE USED, PRACTICE DATES (BEGINNING, ENDING) AND PRACTICE LOCATION(S).

8. HAVE YOU EVER **APPLIED** TO BE RECOGNIZED AS ELIGIBLE TO PRACTICE AS AND USE TITLES OF A NURSE ANESTHETIST, NURSE MIDWIFE, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST BY THE MISSOURI STATE BOARD OF NURSING?

☐ YES, YEAR _____ ☐ NO If yes, as what? _____

9. HAVE YOU EVER BEEN **RECOGNIZED** AS ELIGIBLE TO PRACTICE AS AND USE TITLES OF A NURSE ANESTHETIST, NURSE MIDWIFE, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST BY THE MISSOURI STATE BOARD OF NURSING?

☐ YES, YEAR _____ ☐ NO If yes, as what? _____

***Primary State of residence** means the 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.

NOTE: **You must provide your social security number pursuant to state and federal law.**
If you fail or refuse to provide your social security number, we will consider your initial application or renewal application incomplete and return it to you. Continued failure or refusal to provide your social security number is grounds for denial of your application.

SECTION II - ADVANCED PRACTICE NURSE EDUCATION

NAME & ADDRESS OF ADVANCED PRACTICE PROGRAM	OFFICIAL DATE OF COMPLETION	TYPE OF PROGRAM	OFFICIAL DESIGNATED MAJOR OR CLINICAL SPECIALTY	TYPE OF DEGREE AWARDED
		☐ Nurse Anesthetist ☐ Nurse Midwife ☐ Nurse Practitioner ☐ Clinical Nurse Specialist ☐ Other (Please explain) _____		☐ Certificate ☐ Masters/Nursing ☐ Masters/Other ☐ PhD/Nursing ☐ PhD/Other ☐ Other (Please explain) _____
		☐ Nurse Anesthetist ☐ Nurse Midwife ☐ Nurse Practitioner ☐ Clinical Nurse Specialist ☐ Other (Please explain) _____		☐ Certificate ☐ Masters/Nursing ☐ Masters/Other ☐ PhD/Nursing ☐ PhD/Other ☐ Other (Please explain) _____

SECTION III - 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 CATEGORY	CLINICAL NURSING SPECIALTY AREA	
☐ Nurse Anesthetist		
☐ Nurse Midwife		
☐ Nurse Practitioner	☐ Acute Care ☐ Adult ☐ Family ☐ Gerontological ☐ Neonatal	☐ Women's Health ☐ Pediatric ☐ School ☐ Other (Please explain in a separate sheet of paper)
☐ Clinical Nurse Specialist	☐ Adult Health ☐ Adult Psychiatric and Mental Health ☐ Advanced Oncology ☐ Child/Adolescent Psychiatric and Mental Health	☐ Gerontological ☐ Home Health ☐ Women's Health ☐ Other (Please explain in a separate sheet of paper)

SECTION IV - SPECIALTY CERTIFICATION HELD OR APPLIED FOR

NAME OF NATIONALLY RECOGNIZED CERTIFYING BODY	EXAMINATION DATE	CERTIFICATION NUMBER	CERTIFICATION EXPIRATION DATE	STATUS
				☐ Exam Applicant ☐ Current ☐ Provisional/Conditional ☐ Other (Please explain) _____
				☐ Exam Applicant ☐ Current ☐ Provisional/Conditional ☐ Other (Please explain) _____

Data provided below is **voluntary** and is not required in order to submit an Application for Recognition. This data will assist the department in nurse demographics. **PLEASE PRINT IN BLACK INK.**

GENDER
☐ FEMALE ☐ MALE

RACE/ETHNIC GROUP
☐ CAUCASIAN (WHITE) ☐ AFRICAN-AMERICAN ☐ HISPANIC ☐ AMERICAN INDIAN/ALASKAN NATIVE
☐ ASIAN/PACIFIC ISLANDER ☐ OTHER (if other, please indicate) _____

NATIONALITY
☐ AMERICAN ☐ FOREIGN (please indicate) _____

LANGUAGE
☐ ENGLISH ☐ FOREIGN (please indicate) _____

CITIZENSHIP
☐ UNITED STATES ☐ FOREIGN (please indicate) _____

SECTION V - SCREENING QUESTIONS

1. Have you ever been issued any professional license, certification, registration, or permit by any state, United States, territory, province or foreign country other than the licenses listed above? ☐ YES ☐ NO
   IF YES, IDENTIFY TYPE OF LICENSE, WHEN ISSUED AND BY WHOM.
2. Have you ever been denied a professional license, certification, registration or permit? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.
3. Have you ever had any professional license, certification, registration, or permit revoked, suspended, placed on probation, or otherwise subject to any type of disciplinary action? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.
4. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration, or permit you hold? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.
5. Have you ever voluntarily surrendered or resigned any professional license, certification, registration or permit? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.
6. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime, whether or not sentence was imposed (excluding traffic violations)? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT AND PROVIDE CERTIFIED COPIES OF COURT DOCUMENTS (I.E. DOCKET SHEET, COMPLAINT, AND FINAL DISPOSITION).
7. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol, whether or not sentence was imposed? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT AND PROVIDE CERTIFIED COPIES OF COURT DOCUMENTS (I.E. DOCKET SHEET, COMPLAINT, AND FINAL DISPOSITION).
8. Have you ever had a judgment rendered against you based upon fraud, misrepresentation, deception, or malpractice related to your practice as a registered professional nurse? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT AND PROVIDE CERTIFIED COPIES OF COURT DOCUMENTS (I.E. DOCKET SHEET, COMPLAINT, AND FINAL DISPOSITION).

SECTION VI - AFFIDAVIT (TO BE NOTARIZED BY A NOTARY PUBLIC) — ALL APPLICANTS

I am aware that all documents needed for recognition as eligible to practice as and use titles of an advanced practice registered nurse must be received in the Board office before my application expires. I am also aware that it is my legal and professional responsibility to inquire at the Board office before my application expires regarding the status of my application. Application fees are non-refundable.

I realize that I cannot practice as nor use titles of an advanced practice registered nurse without a current Missouri OR another Compact State RN license, certification and Board recognition.

I understand that my application for recognition will not be approved if I fail to provide any of the required documentation or information.

Being duly sworn, I state that I am the person who is referred to in the foregoing application for eligibility to practice as and use titles of an advanced practice registered nurse in the State of Missouri; that the statements therein are strictly true in every respect; that I have complied with all requirements of the law; and that I have read and understand this affidavit.

MUST BE SIGNED IN PRESENCE OF NOTARY ▶		
NOTARY PUBLIC EMBOSSER SEAL	STATE	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR	**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE / MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	

FOR OFFICE USE ONLY **DO NOT WRITE ON THIS PAGE**

NAME (LAST, FIRST, MIDDLE INITIAL)

RN LICENSE NUMBER

DATE/INIT

TSRP

RN EXP

MAIDEN AND/OR PREVIOUS NAMES

☐ NEVER RECOGNIZED ☐ EXPIRED RECOGNITION ☐ PRACTICE WITHOUT RECOGNITION

NAME: _____
(LAST, FIRST, MIDDLE INITIAL)

	ITEM	REC'D	PROC'D	INIT
	REQUEST			
	FEE			
	APPLICATION			
	RN LICENSE			
NONCERTIFIED GRADUATE				
	EXAMINATION DOCUMENT			
	EXAM DATE NOTARIZED STATEMENT			
	TRANSCRIPT-MASTERS			
	TRANSCRIPT-POST MASTERS			
	TRANSCRIPT-CERTIFICATE			
	TRANSCRIPT-OTHER			
	OTHER			
CERTIFIED				
	EXAMINATION RESULTS			
	EXAMINATION RESULTS-RETEST			
	EXAMINATION RESULTS-RETEST			
	CERTIFICATION CARD/WALL CERT			
	CONSENT TO RELEASE FORM			
	OTHER			
NONCERTIFIED				
	NONCERTIFICATION EVIDENCE			
	CLINICAL HOURS			
	PHARMACOLOGY EVIDENCE			
	TRANSCRIPT-MASTERS			
	TRANSCRIPT-POST MASTERS			
	TRANSCRIPT-CERTIFICATE			
	TRANSCRIPT-OTHER			
	TRANSCRIPT CLARITY			
	TRANSCRIPT CLARITY			
	OTHER			
FINAL APPROVAL				

COMMENTS

BOARD OF NURSING
P.O. BOX 656
JEFFERSON CITY, MO 65102-0656
TELEPHONE (573) 751-0681
TEXT TELEPHONE (TTY)
1-800-735-2966
HEARING IMPAIRED
http://pr.mo.gov

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

CONSENT TO RELEASE CERTIFICATION INFORMATION

PLEASE SEND THIS FORM TO YOUR CERTIFYING BODY.
CHECK WITH CERTIFYING BODY TO DETERMINE APPLICABLE FEES.

NAME OF LICENSEE (PRINT)	MISSOURI RN LICENSE NUMBER

CURRENT ADDRESS OF LICENSEE

CERTIFICATION NUMBER (IF APPLICABLE)	EXPIRATION DATE

TYPE OF CERTIFICATION

☐ NURSE ANESTHETIST ☐ NURSE MIDWIFE ☐ NURSE PRACTITIONER ☐ CLINICAL NURSE SPECIALIST

NAME OF CERTIFYING BODY

I authorize the above named certifying body to disclose information regarding the identification, evaluation, and certification of the *above named licensee that is maintained by the above named certifying body to the Missouri State Board of Nursing, its* representatives and the Administrative Hearing Commission or court. I authorize the Missouri State Board of Nursing to utilize this information as needed for validation, investigation, litigation, discipline, or agreements concerning my nursing license.
This authorization to release the above requested information shall expire at my written request.
A copy of this request shall be as effective as the original.

SOCIAL SECURITY NUMBER (VOLUNTARY, USED FOR IDENTIFICATION PURPOSES ONLY)

SIGNATURE OF LICENSEE ▶	DATE

SIGNATURE OF WITNESS ▶	DATE

INFORMATION REQUESTED BELOW TO BE COMPLETED BY CERTIFYING BODY

NAME OF PERSON CERTIFIED	INITIAL DATE OF CERTIFICATION

CERTIFICATION NUMBER (IF APPLICABLE)	EXPIRATION DATE OF CURRENT CERTIFICATION/MAINTENANCE CYCLE

Type of Certification:

☐ Nurse Anesthetist
☐ Nurse Midwife
☐ Nurse Practitioner - specify specialty area _____
☐ *Clinical Nurse Specialist - specify specialty area* _____

1. Is certification current?	☐ Yes	☐ No**
2. Has certification lapsed?	☐ Yes**	☐ No
3. Has certification been revoked?	☐ Yes**	☐ No
4. Is certification provisional or conditional in any manner?	☐ Yes**	☐ No
5. Is actively and satisfactorily participating in meeting recertification/maintenance terms *and/or continuing education/competency requirements?*	☐ Yes	☐ No**

Please explain 'no' response to number 1 and number 5 and 'yes' responses to numbers 2, 3 or 4:

_____

_____

NAME OF CERTIFYING BODY

NAME OF PERSON COMPLETING INFORMATION REQUESTED	TITLE	DATE