



**STATE OF MISSOURI**  
**DIVISION OF PROFESSIONAL REGISTRATION**  
**APPLICATION FOR LICENSE AS A LICENSED**  
**PRACTICAL NURSE BY EXAMINATION**  
**- AIR FORCE PROGRAM ONLY**

Missouri State Board of Nursing  
 P.O. Box 656, Jefferson City, MO 65102-0656  
 (573) 751-0681  
 Text Telephone (TT) 1-800-735-2966 (Hearing Impaired)  
 Website: <http://pr.mo.gov> Email: [nursing@pr.mo.gov](mailto:nursing@pr.mo.gov)

FOR OFFICE USE ONLY			
LIC APPROVED	EDUCATION APPROVED	LIC DATE	LIC NUMBER
CASE NO	APPROVED	LAWFUL PRESENCE	LAWFUL PRESENCE EXP DATE
NURSYS	BG CHECK	TRANSCRIPT	DEEMED ELIGIBLE
PRE LIC NO	MEMO		

Place a checkmark in the shaded area below for changes/notes on application. See note section for clarification.

APPLICATION IS RETIRED AND VOID IF REQUIREMENTS FOR LICENSURE ARE NOT MET WITHIN ONE YEAR FROM THE DATE THAT THE APPLICATION WAS NOTARIZED AND A NEW APPLICATION WILL NEED TO BE SUBMITTED TO BE CONSIDERED FOR LICENSURE.

**PROFILE INFORMATION**

FULL NAME (LAST) (FIRST) (MIDDLE) (MAIDEN)

PREVIOUS OR OTHER NAME(S)

\*PRIMARY RESIDENCE (Where you vote, pay federal taxes, obtain a driver's license) – PHYSICAL ADDRESS REQUIRED, **PO BOXES ARE NOT ACCEPTABLE**

CITY STATE ZIP CODE

MAILING ADDRESS (IF DIFFERENT THAN PRIMARY RESIDENCE) STREET OR P.O. BOX

CITY STATE ZIP CODE

SOCIAL SECURITY NO. (MANDATORY, USED FOR IDENTIFICATION PURPOSES ONLY) TELEPHONE NO. - HOME TELEPHONE NO. - WORK

E-MAIL ADDRESS (PLEASE PRINT)

DATE OF BIRTH (MONTH DAY YEAR) PLACE OF BIRTH (CITY) (STATE) (COUNTY) MOTHER'S MAIDEN LAST NAME

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) \_\_\_\_\_

MILITARY STATUS  
 ACTIVE  GUARD/RESERVE  RETIRED  SEPARATED

\*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.

I declare \_\_\_\_\_ as my primary state of residence effective \_\_\_\_\_.  
 (PRIMARY STATE OF RESIDENCE) (EFFECTIVE DATE)

My primary state of residence is another compact state; however, I do not qualify for a multistate license in my primary state of residence so I am requesting a Missouri single state license.

I am employed exclusively in the U.S. Military (Active Duty) or with the U.S. Federal Government and am requesting a Missouri single-state license regardless of my primary state of residence.

**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 NOTARIZED STATEMENT.**  YES  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 NOTARIZED STATEMENT.**  YES  NO
- 3a. Are you currently a participant in a state board/designee monitoring program including alternative to discipline, diversion or a peer assistance program? **IF YES, PROVIDE A WRITTEN NOTARIZED EXPLANATION INCLUDING THE STATE, DATES AND REASON FOR PARTICIPATION.**  YES  NO
- 3b. Have you ever been terminated from or refused to enter an alternative to discipline, diversion, or a peer assistance program? **IF YES, PROVIDE A WRITTEN NOTARIZED EXPLANATION INCLUDING THE STATE, DATES AND REASONS FOR PARTICIPATION AND TERMINATION.**  YES  NO
4. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration, or permit you hold? **IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.**  YES  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 NOTARIZED STATEMENT.**  YES  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 NOTARIZED STATEMENT AND PROVIDE CERTIFIED COPIES OF COURT DOCUMENTS (I.E. DOCKET SHEET, COMPLAINT, AND FINAL DISPOSITION).**  YES  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 NOTARIZED STATEMENT AND PROVIDE CERTIFIED COPIES OF COURT DOCUMENTS (I.E. DOCKET SHEET, COMPLAINT, AND FINAL DISPOSITION).**  YES  NO
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? **IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT AND PROVIDE CERTIFIED COPIES OF COURT DOCUMENTS (I.E. DOCKET SHEET, COMPLAINT, AND FINAL DISPOSITION).**  YES  NO
9. Do you have any condition or impairment, including a history of alcohol or substance abuse that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? **IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT**  YES  NO
10. Are you currently participating in a substance abuse and/or alcohol or drug treatment program or been diagnosed with a substance abuse disorder which in any way currently affects or limits your ability to practice safely and in a competent and professional manner? **IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT AND PROVIDE ANY DOCUMENTATION THAT SHOWS YOUR DIAGNOSIS, PROGNOSIS, AND TREATMENT PLAN.**  YES  NO
11. Are you listed on any state or federal sexual offender registry? **IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.**  YES  NO
12. Have you ever been placed on an employee disqualification list or other related restriction of finding pertaining to employment within a health-related profession issued by state or federal government or agency? **IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.**  YES  NO

Pursuant to Section 324.010 RSMo:

**CHECK THIS BOX ONLY IF IN ALL OF THE LAST 3 YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.**

*False statements are subject to criminal penalties and/or license discipline.*

**If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail [income@dor.mo.gov](mailto:income@dor.mo.gov).**

**RELEASE**

I authorize  do not authorize the Missouri State Board of Nursing to release any and all information regarding my licensure and exam application status as a Licensed Practical Nurse to my nursing education program as identified in this foregoing application and/or their representatives.

This release authorizes the Missouri State Board of Nursing to release my name, address, nursing school name, graduation date, eligibility status, test appointment date, date exam was taken, whether or not I took the exam, examination results and my NCLEX Candidate Performance Report.

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

**AFFIDAVIT (TO BE NOTARIZED BY A NOTARY PUBLIC)**

I am aware that all documents needed for licensure by examination must be received in the Board office before my original 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.

Being duly sworn, I state that I am the person who is referred to in the foregoing application for licensure as a Licensed Practical Nurse in the State of Missouri; that the statements therein are strictly true in every respect; that I have complied with all requirements of law; that I am of good moral character; and that I have read and understood this affidavit. 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.

<b>MUST BE SIGNED IN PRESENCE OF NOTARY</b> ▶		APPLICANT SIGNATURE	
STATE OF	COUNTY (OR CITY OF ST. LOUIS)	NOTARY PUBLIC EMBOSSER SEAL	
SUBSCRIBED AND SWORN BEFORE ME, THIS			<b>USE RUBBER STAMP IN CLEAR AREA BELOW.</b>
DAY OF 20			
NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES		
NOTARY PUBLIC NAME (TYPED OR PRINTED)			

**FOR OFFICE USE ONLY - NOTES**



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
**VERIFICATION OF AIR FORCE BASIC MEDICAL  
 TECHNICIAN CORPSMAN PROGRAM (BMTCP)  
 4N051/4N071 (4N TRAINING PROGRAM)**

**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>

**EXPRESS MAIL DELIVERY  
 ADDRESS:**  
 3605 MISSOURI BOULEVARD  
 JEFFERSON CITY, MO 65109

**SECTION I - PERSONAL INFORMATION**

FULL NAME (LAST, FIRST, MIDDLE, MAIDEN)

SOCIAL SECURITY NUMBER

DATE OF BIRTH  
 MONTH

DAY

YEAR

**SECTION II - AFFIRMATION**

**This section MUST be completed by the 4N Unit Training Manager, 4N Functional Manager or Chief Nurse Officer.**

I verify that the person named in this document has completed the **Basic Medical Technician Corpsman program (BMTCP) 4N501/4N071 (4N training program) – 5 skill level or above.**

I have personally met with the person named in this document and reviewed the requirements for licensure as a practical nurse. This person has taken a review course.

DATE OF COMPLETION OF 5 SKILL LEVEL OF 4N TRAINING

SIGNATURE OF THE 4N UNIT TRAINING MANAGER, 4N FUNCTIONAL MANAGER OR CHIEF NURSE OFFICER

PROGRAM CODE

**US17110000**

PHYSICAL MAILING ADDRESS

EMAIL ADDRESS

PHONE NUMBER

**SECTION III - INSTRUCTIONS**

If you are:

**Active Duty – 4N051/4N071 without Community College of the Air Force (CCAF) LPN degree, provide:**

1. Completed Air Force User Profile document.
2. Completed Specialty Training Standards document.

**4N051/4N071 with CCAF LPN degree, provide:**

1. Career Data Brief – indicating the CCAF LPN degree
2. Transcript from CCAF

**If you are, Veteran/separated from active duty – 4N051/4N071, provide:**

1. DD 214 Form
2. Completed Specialty Training Standards document