



APPLICATION FOR ADVANCED REGISTERED NURSE PRACTITIONER

Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. and the Iowa Code. The number will be used in connection with the collection of child support, college student loans, debts owed to the state of Iowa, and as an internal means to accurately identify licensees. This information will also be shared with taxing authorities as allowed by law. Ref: 42 U.S.C. § 666(a)(13), Iowa Code §§ 252J.8(1), 261.126(1) (2007), § 272D.8(1) (Supp. 2008), § 421.18 (2007). Information is collected pursuant to Iowa Code 147.10 and Iowa Administrative Code 655-Chapter 3, will be used for workforce projections, and may be disclosed pursuant to IAC 655-Chapter 11. Failure to provide mandatory information will result in license denial.

SECTION A - PERSONAL INFORMATION

IT IS ILLEGAL TO PRACTICE NURSING IN IOWA WITHOUT A CURRENT LICENSE

Notification to the Board of name and address changes is mandatory as defined in IAC Section 147.9. (Address changes can be made online. Name changes are required to be submitted in writing)

- 1. Legal Name First Middle Last
- 2. Other Last Name(s)
- 3. Residential Address
- 4. P.O. Box
- 5. City
- 6. State
- 7. Zip Code
- 8. County
- 9. Country
- 10. Primary Phone Number
- 11. Mobile Phone Number
- 12. Other Phone Number
- 13. E-Mail Address
- 14. Social Security #

PRIMARY STATE OF RESIDENCE – ARNP’s are NOT a part of the RN nurse license compact agreement. ARNP’s must hold an RN license in their primary state of residence.

Iowa is a member of the Nurse Licensure Compact Agreement. The nurse licensure compact allows a nurse who resides in a compact state to hold ONE license in the nurse’s primary state of residence and practice in all other states in which the compact is in effect. As a condition of obtaining a license in a compact state, you are REQUIRED to declare your primary State of residence. Primary state of residence is your declared fixed permanent and principal home for legal purposes and is your domicile. Evidence of the nurse’s primary state of residence shall include a declaration signed by the licensee. Further evidence that may be requested may include, but are not limited to, a driver’s license with a home address, voter registration card displaying a home address, Federal income tax return declaring the primary state of residence, Military Form No. 2058 or a W-2 from the U.S. government or any bureau, division or agency thereof indicating the declared state of residence. (IAC 655—16)

- 1. My Current Primary State of Residence is:
- 2. Are you a Veteran? Yes No
- 3. Are you a Spouse of a Veteran? Yes No

SECTION B - DEMOGRAPHICS

1. Date of Birth (mm/dd/yyyy)

2. Gender
 - Female
 - Male

3. Race/Ethnicity
 - White, Caucasian
 - Black, African American
 - American Indian or Alaska Native
 - Asian
 - Hispanic/Latino
 - Pacific Islander
 - Multi-racial
 - Other

4. Entry Level Education What type of nursing degree/credential qualified you for your first RN U.S. nursing license.
 - Vocational/Practical Certificate
 - Diploma (RN Only)
 - Associate Degree
 - Baccalaureate Degree
 - Master's Degree
 - Doctoral Degree
 - Other

5. Highest Level of Education What is your highest level of education?
 - Vocational/Practical Certificate-Nursing
 - Diploma-Nursing (RN Only)
 - Associate Degree-Nursing
 - Associate Degree-Non-Nursing
 - Baccalaureate Degree-Nursing
 - Baccalaureate Degree-Non-Nursing
 - Master's Degree-Nursing
 - Master's Degree-Non-Nursing
 - Doctoral Degree-Nursing (PhD)
 - Doctoral Degree-Nursing Practice (DNP)
 - Doctoral Degree-Nursing Other
 - Doctoral Degree-Non-Nursing

SECTION C – APPLICANT INFORMATION

1. Check the ARNP category(s) applying for. (The category **MUST** match your certification)
 - A - Certified Family Nurse Practitioner
 - A – Family/Individual Across the Lifespan
CNP
 - B - Certified Nurse-Midwife
 - C - Certified Pediatric Nurse Practitioner
 - C – Pediatric Acute Care CNP
 - C – Pediatric Primary Care CNP
 - D - Certified Registered Nurse Anesthetist
 - E - Certified School Nurse Practitioner
 - F - Certified Women's Health Care Nurse
Practitioner
 - F - Women's Health/Gender Related CNP
 - G - Certified Psych/Mental Health Nurse
Practitioner
 - G – Psychiatric Mental Health Across the
Lifespan CNP
 - H - Certified Adult Nurse Practitioner
 - H – Adult/Gerontology Acute Care CNP
 - H – Adult/Gerontology Primary Care CNP
 - I - Certified Clinical Nurse Specialist
 - J - Certified Gerontological Nurse
Practitioner
 - K - Certified Neonatal Nurse Practitioner
 - K - Neonatal CNP
 - L - Acute Care Nurse Practitioner
 - M - Perinatal Nurse Practitioner
 - P – Family/Individual Across the Lifespan
CNS
 - Q - Clinical Nurse Specialist – Adult Health
 - Q – Adult/Gerontology Wellness through
Acute Care CNS
 - Q – Womens' Health/Gender Related
Wellness through Acute CNS
 - R - Clinical Nurse Specialist - Perinatal
 - S - Clinical Nurse Specialist -
Medical/Surgical
 - T - Clinical Nurse Specialist - Adult Psych.
 - T – Psychiatric Mental Health CNS
 - U - Clinical Nurse Specialist - Oncology
 - V - Clinical Nurse Specialist - Gerontology
 - W - Clinical Nurse Specialist - Orthopedics
 - X - Clinical Nurse Specialist – Community
Health
 - Y - Clinical Nurse Specialist - Home Health
 - Z – Clinical Nurse Specialist – Child
Adolescent Psych
 - Z – Pediatric Wellness through Acute Care
CNS
 - Z –Neonatal Wellness through Acute Care
CNS

2. List all Registered Nurse Licenses held in ANY State.

State(s)

License number(s) (if known)

Expiration Date(s) (mm/dd/yyyy)

SECTION D - EDUCATIONAL PROGRAM INFORMATION

Official transcript must be submitted directly from the formal advanced practice educational program maintaining the records necessary to document that all requirements have been met in one of the specialty areas of nursing practice as listed in subrule 7.2(1). The transcript shall verify the date of completion of the program/graduation and the degree conferred. A registered nurse may make application to practice in more than one specialty area of nursing practice. This information shall be received prior to issuing the registration.

1. Basic Educational Program Attended (Program which qualified you to sit for the RN licensing exam).

Nursing Program Name

Nursing Program Location (City & State)

2. Date of Graduation or Date Degree Conferred by the Basic Educational Program.

dd/mm/yyyy

3. Name of Advanced Practice Educational Program Attended.

Advanced Nursing Program Name

Advanced Nursing Program Location (City & State)

4. What type of Advanced Practice Educational Program?

- Master's Degree
- Post Master's (Certificate)
- Doctoral Degree-Nursing Practice (DNP)

5. What was the Program Major (Specialty Area)?

6. Date of Advanced Practice Educational Program Graduation.

mm/dd/yyyy

SECTION E – NATIONAL PROFESSIONAL CERTIFYING BODY

1. Certifying Body (Select All That Apply)

- American Nurses Credentialing Center
- American Midwifery Certification Board
- American Academy of Nurse Practitioners
- Council of Certification of Nurse Anesthetists or Re-Certification of Nurse Anesthetists
- National Certification Board of Pediatric Nurse Practitioners and Nurses
- National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Certification Corporation
- Oncology Nursing Certification Corporation
- American Association of Critical Care Nurses Certification Corporation
- Pediatric Nursing Certification Board

2. Certified From: mm/dd/yyyy to
 Certified From: mm/dd/yyyy to

A copy of the time-dated, advanced level certification by appropriate national certifying body evidencing that the applicant holds current certification in good standing must be submitted with this application. You can either attach a copy to this application or scan and email the document to newnurs@iowa.gov or fax to 515-281-4825. Note: This application will not be processed until documentation is received.

SECTION F - CRIMINAL OFFENSE OR DISCIPLINED/SURRENDERED LICENSE INFORMATION

All criminal convictions and/or disciplinary actions taken by another licensing authority **MUST** be reported to the Iowa Board of Nursing within 30 days of the action pursuant to 655 IAC 4.6(3)"d" and "e".

1. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, Alford pleas, or no contest to a crime other than a minor traffic offense, in any jurisdiction? Driving while under the influence or driving while impaired must be reported.

You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must answer "Yes" if you received a deferred judgment or if the conviction was expunged.)

Failure to report all criminal history may result in disciplinary action.

- Yes
 No

2. If yes, has the Iowa Board of Nursing formally reviewed all of these criminal actions?

- Yes
 No If No, submit a copy of the sentencing order with this application (See ARNP Instructions)

3. Has your license to practice or privilege to practice nursing, or any health care profession, ever been disciplined, surrendered or denied in this state or any other state(s)?

- Yes
 No

4. If yes, has the Iowa Board of Nursing formally reviewed this action(s)?

- Yes
 No If No, list all state(s) and submit board documentation

SECTION G – EMPLOYMENT

1. Are you currently employed/self employed in nursing or in a position that requires an active nursing license?

- Yes
 No If No, continue to **SECTION H - EMPLOYMENT STATUS**

2. If Yes, in what state(s) will you be employed?

3. In how many positions are you currently employed as a nurse?

4. Are you employed by the federal government or on active military duty? Yes No

The following questions are referring to your Primary Employer. Primary Employer is defined as where you work the majority number of hours per week.

5. Primary Employer Name

6. Primary Employer State Zip Code

7. Primary Employer County Name County Number (if known)

8. Primary Employer Phone Number

9. What is your primary employment status?

- Full-time
- Part-time
- Per Diem

10. Average Hours you will work in a nursing position.

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> <10 | <input type="checkbox"/> 31-40 |
| <input type="checkbox"/> 10-20 | <input type="checkbox"/> 41-50 |
| <input type="checkbox"/> 21-30 | <input type="checkbox"/> >50 |

In 2001, the legislature passed a law mandating that licensing boards require a person who regularly examines, attends, counsels or treats dependent adults or children in Iowa to accurately document compliance with training requirements on abuse education and/or dependent adult abuse, upon license renewal.

8. Do you as an ARNP or RN, examine, attend, counsel, or treat children or dependent adults in Iowa on a regular basis?

- Yes
- No

SECTION H - EMPLOYMENT STATUS

1. What will be your employment status? (If you choose a., b., d. or e., Answer Questions 2 & 3 and continue to Sections K & L)

- a. Actively employed in a healthcare field other than nursing
- b. Actively employed in a non-healthcare field
- c. Actively employed in nursing or in a position that requires a nurse license
- d. Retired
- e. Unemployed
- f. Working in nursing as a volunteer

2. Are you seeking nursing employment?

- Yes
- No

3. Please share the primary reason that you are not currently employed in nursing.

- Difficulty in finding a nursing position
- Disabled
- Inadequate Salary
- Other
- School
- Taking care of home and family

SECTION I - EMPLOYMENT SETTING

1. Please identify the type of setting that most closely corresponds to your primary nursing practice position. (Choose only one)

- | | |
|--|--|
| <input type="checkbox"/> Academic Setting | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Community Health | <input type="checkbox"/> Office/Clinic/Ambulatory Care Setting |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Other |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Policy/Planning/Regulatory/Licensing Agency |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Insurance Claims/Benefits | <input type="checkbox"/> School Health Service |
| <input type="checkbox"/> Long Term Care/Extended Care/Assisted Living Facility | |

SECTION J - EMPLOYMENT POSITION

1. Please identify the position title that most closely corresponds to your primary nursing practice position. (Choose only one)

- | | |
|--|---|
| <input type="checkbox"/> Advanced Practice Nurse | <input type="checkbox"/> Nurse Researcher |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Other-Health Related |
| <input type="checkbox"/> Nurse Director/Manager | <input type="checkbox"/> Other-Not Health Related |
| <input type="checkbox"/> Nurse Executive/Administrator | <input type="checkbox"/> Staff Nurse |
| <input type="checkbox"/> Nurse Faculty | |

SECTION K - EMPLOYMENT SPECIALTY

1. Please identify the employment specialty that most closely corresponds to your primary nursing practice position. (Choose only one)

- | | |
|---|--|
| <input type="checkbox"/> Acute Care/Critical Care | <input type="checkbox"/> Other |
| <input type="checkbox"/> Adult Health/Family Health | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Pediatrics/Neonatal |
| <input type="checkbox"/> Community | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Geriatric/Gerontology | <input type="checkbox"/> Psychiatric/Mental Health/Substance Abuse |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Maternal-Child Health | <input type="checkbox"/> School Health |
| <input type="checkbox"/> Medical Surgical | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Occupational Health | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Oncology | |

SECTION L – FEES

- 1. \$81.00 Add \$81.00 for each additional ARNP Category

SECTION M – SIGNATURE

Please read the following statement and confirm agreement by signing this application

Signature-I certify that this complete application and all submitted materials contain no willful misrepresentation and that the information is true and complete to the best of my knowledge. I understand that should an investigation at any time disclose otherwise, my application may be rejected, and I may face legal sanctions if I am already licensed. I also understand that, in compliance with Iowa Code, Chapter 22, information on this application will be public record and may be available to the public upon request, except for applicable laws. Finally, I understand that in submitting this application for licensure, I am consenting to any reasonable inquiry that may be necessary to verify the information I have provided on this form or may provide in conjunction with my application.

Name _____
(Print)

Signature _____

Date _____