

DELAWARE BOARD OF NURSING
861 SILVER LAKE BLVD., SUITE 203, DOVER, DELAWARE 19904
(302) 744-4500

APPLICATION FOR REINSTATEMENT OF LAPSED NURSING LICENSE

1. This form is to be completed, including the affidavit, and returned with the non-refundable fees. (refer to the enclosed fee schedule)
2. If you have practiced 1000 hours or more in the past five years or 400 hours in the past two years, complete and sign the enclosed reference request form and forward to your nursing employer(s) who can verify your most recent six months of nursing employment. They will mail the completed form directly to this office; **OR**
3. If you have been inactive in nursing for five or more years, you must present evidence of successfully completing an approved refresher program within a two-year period prior to submitting this application.
4. You must complete the verification of continuing education form indicating the courses/programs you have completed within the past two years. RNs are required to submit 30 contact hours, and LPNs are required to submit 24 contact hours.
5. If your name has been changed since you were last licensed in Delaware, enclose a copy of your marriage certificate or court action.

NAME _____
Last First Middle Maiden

ADDRESS _____
Street City State Zip Code

S.S. # _____ **PHONE #** _____ **RN** [] **LPN** []

DELAWARE NURSING LICENSE NUMBER _____ **YEAR ISSUED** _____

LICENSED IN WHAT OTHER STATE(S)? _____

List below names and full addresses of all nursing employers and dates of employment in the past five years.

<u>NAME</u>	<u>ADDRESS</u>	<u>DATES</u>

(OVER)

MINIMAL HOURS – Delaware law requires that you meet the practice requirement within the past five years to obtain licensure in Delaware.

Practice Requirement (You must check at least one)

I have practiced nursing AT LEAST:

- 1,000 hours in the past five years
- 400 hours in the past two years
- Completed a Refresher Course in the past two years (submit evidence)
- Completed an alternate supervised practice plan (submit evaluation)
- None of the above.

1. Has any license to practice nursing ever been surrendered, suspended, revoked, probated, or otherwise disciplined? NO YES If yes, in what state(s)? _____
2. Is any license to practice nursing currently under investigation? NO YES If yes, in what state(s)? _____
3. Have you ever been denied licensure in Delaware or any state? NO YES If yes, in what state(s)? _____
4. Have you ever been convicted of a felony? NO YES
5. Are you now dependent upon the use of alcohol, stimulants, or habit-forming drugs? NO YES

If you answered yes to questions 1 - 5, please explain below and attach the corresponding legal documents.

A F F I D A V I T

To Be Notarized:

County of: _____ State of: _____

_____, being duly sworn, stated that he/she is the person referred to in the foregoing application for reinstatement of a lapsed license to practice nursing in the State of Delaware; that the statements contained herein are true and that he/she has read and understands this affidavit.

Signature of Applicant

Sworn before me on this _____ day of _____, in the year _____.

Notary Public My _____ commission
expires: _____

APPLICATION FOR TEMPORARY PERMIT:

Complete the temporary permit application if employment has been offered. You cannot begin employment or orientation in Delaware without a temporary permit or Delaware licensure.

Date to begin employment: _____ Employer: _____

Employer's Address _____

Phone number: _____ Contact person: _____

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TO: APPLICANTS FOR LICENSURE BY REINSTATEMENT

FROM: Iva J. Boardman, RN, MSN, Executive Director
Delaware Board of Nursing

RE: Application Fee Schedule and Instructions for Reinstatement

DATE: Effective as of July 1, 2003

Please review the following instructions carefully before submitting your application to our office.

- 1) Using your license number, include the fee listed for the month that you are submitting your application. The listed fees include a \$33.00 late fee. Checks should be made payable to the State of Delaware. The fee is non-refundable. Please contact the Board office at (302) 744-4516 or 744-4515 if you have questions. Thank you.
- 2) **MUTUAL LICENSURE RECOGNITION INFORMATION** - The following states have implemented the Nurse Licensure Compact (Arizona, Arkansas, Delaware, Idaho, Iowa, Maine, Maryland, Mississippi, Nebraska, North Carolina, South Dakota, Tennessee, Texas, Utah, and Wisconsin). North Dakota and New Mexico will implement on January 1, 2004. Virginia will implement on January 1, 2005. Indiana and New Jersey have passed the legislation but have not yet established implementation dates. It is anticipated that more states will pass the legislation extending the multistate practice privilege throughout the country.

The compact creates mutual recognition of nursing licenses among the compact states listed above. A nurse living in a compact state can practice nursing in any other compact state without obtaining a license in that state. The nurse licensure compact works like the driver's license. A driver's license allows you to drive in any compact state as long as you have obtained a license in your state of residence.

IF YOU LIVE IN A COMPACT STATE, the following rules apply:

- 1) **The compact requires that you hold a license only in your declared state of residence to practice in all other compact states. You must apply for licensure by examination in your home state of residence.**
- 2) **If Delaware is not your declared state of residence, you need to now apply for licensure in your declared state of residence, since the licenses that you carry in other compact states will become invalid. Should you change residence to another compact state, you will need to obtain a license in your new state of residence and relinquish the license from your previous state of residence.**
- 3) **If you move to a non-compact state, your license in the previous compact state will remain valid for practice only in that state. It will no longer carry the multistate practice privilege, since you no longer live in a compact state.**

5) You will continue to need to seek licensure in all non-compact states in which you practice.

(OVER)

REGISTERED NURSES: Please refer to your Delaware license number to determine your licensure "Group" below:

GROUP "A" – LICENSE NUMBERS 000001 TO 0017,000 –

Licensure through 2/28/05

June, 2003	\$92.00	January, 2004	\$73.00
July, 2003	\$89.00	February, 2004	\$70.00
August, 2003	\$87.00	March, 2004	\$67.00
September, 2003	\$84.00	April, 2004	\$64.00
October, 2003	\$81.00	May, 2004	\$61.00
November, 2003	\$78.00	June, 2004	\$59.00
December, 2003	\$75.00		

GROUP "B" – LICENSE NUMBERS 17,001 – 24,000 –

Licensure through 5/31/05

June, 2003	\$100.00	January, 2004	\$81.00
July, 2003	\$98.00	February, 2004	\$78.00
August, 2003	\$95.00	March, 2004	\$75.00
September, 2003	\$92.00	April, 2004	\$73.00
October, 2003	\$89.00	May, 2004	\$70.00
November, 2003	\$87.00	June, 2004	\$67.00
December, 2003	\$84.00		

GROUP "C" – LICENSE NUMBER 24,001 UP –

Licensure through 9/30/05

June, 2003	\$112.00	January, 2004	\$92.00
July, 2003	\$109.00	February, 2004	\$89.00
August, 2003	\$106.00	March, 2004	\$87.00
September, 2003	\$103.00	April, 2004	\$84.00
October, 2003	\$100.00	May, 2004	\$81.00
November, 2003	\$98.00	June, 2004	\$78.00
December, 2003	\$95.00		

LICENSED PRACTICAL NURSES:

Licensure through 2/28/04

June, 2003	\$59.00	January, 2004	\$106.00
July, 2003	\$56.00	February, 2004	\$103.00
August, 2003	\$53.00	March, 2004	\$100.00

Licensure through 2/28/06

September, 2003	\$117.00	April, 2004	\$98.00
October, 2003	\$114.00	May, 2004	\$95.00
November, 2003	\$112.00	June, 2004	\$92.00
December, 2003	\$107.00		

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DECLARATION OF PRIMARY RESIDENCE

I hereby declare that I am a resident of the State of _____.

Print Name _____

Signature _____

Date _____

ATTACH A PHOTOCOPY OF YOUR DRIVER'S LICENSE OR OFFICIAL
IDENTIFICATION CARD FROM THE DIVISION OF MOTOR VEHICLES IN YOUR
STATE.

Attach photocopy here.

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REFERENCE FORM FOR LICENSURE PURPOSES ONLY

The applicant must complete the front page of this form and forward it to all of their employer(s) who comprise the most recent six months of nursing practice. If you were a new graduate within the past year and have not been employed as a nurse for at least six months, please also send this form to your school of nursing for completion, in addition to any nursing employers. The employer/school of nursing will complete the form and return it directly to the Board office. **WE CANNOT ACCEPT THE FORM IF IT IS RETURNED BY THE APPLICANT.**

Name of Applicant _____
(Please Print) (Last) (First) (Maiden)

Applicant's Address _____
(Street) (City) (State) (Zip Code)

RN _____ LPN _____ Social Security # _____

EMPLOYER: _____ () _____
Name of Employer Telephone Number

_____ Address

_____ City State Zip Code

The applicant whose name appears above has applied for licensure in Delaware. Please complete this form on the reverse side and return it to the **Delaware Board of Nursing**. Thank you for your assistance.

Iva J. Boardman, RN, MSN
Executive Director

FROM: Applicant for Delaware Licensure
RE: Release Statement

As an applicant for licensure in the State of Delaware, I hereby authorize release of reference information relative to my employment/nursing education at the above named institution.

SIGNATURE: _____

DATE: _____

ARTICLE VI, SECTION 5.1:2 of the Rules and Regulations of the Delaware Board of Nursing mandates a reference from the applicant's immediate past employer(s) for the most recent six months of nursing employment. In the event of no previous nursing employment, the reference shall be provided from the Director of the applicant's approved nursing education program. Any unsatisfactory reference shall be brought to the attention of the Board for review.

A. EMPLOYER: Please complete Section A and sign and date at the bottom of the page.

The individual named on the front of this reference request form was/is employed as an:

LPN _____ RN _____ APN _____

FROM: _____
Month/Day/Year

TO: _____
Month/Day/Year

Based upon this individual's performance, would you recommend this individual for licensure?

YES _____ **NO** _____ **CURRENTLY EMPLOYED** _____

NOTE: If you checked no, please state specifics. Your answer is a factor in determining eligibility for Delaware licensure.

If you were a new graduate within the past year and have not been employed as a nurse for at least six months, please also send this form to your school of nursing for completion, in addition to any nursing employers.

B. SCHOOL OF NURSING: Please complete Section B. and sign and date below.

The individual named on the front of this reference request form completed the RN _____ or PN _____ educational program at:

NAME OF SCHOOL: _____

GRADUATION DATE: _____

MUST BE SIGNED AND DATED

Name of Employer/School of Nursing _____

Name of Person Completing Form _____

Title _____ Signature _____

Telephone # _____ DATE _____

RETURN FORM TO:

DELAWARE BOARD OF NURSING
861 SILVER LAKE BLVD, CANNON BLDG., SUITE 203
DOVER, DE 19904

DO NOT FAX THIS FORM

Rev. 04/03

DELAWARE BOARD OF NURSING
Verification of Continuing Education

COMPLETE THIS FORM AND SUBMIT WITH YOUR REINSTATEMENT APPLICATION.

Instructions:

- 1) Please print or type **ALL** information. **THIS FORM CANNOT BE FAXED!**
- 2) List complete dates (M/D/Y) as stated on certificate, complete course names, complete names of providers (not the presenters) and number of contact hours awarded for continuing education in the chart below. Additional space is on page 2. Initials for courses and providers cannot be accepted. **Continuing education must be listed on this form.**
- 3) **Sign and date in the space provided.**

PLEASE NOTE: YOU MUST HAVE A CERTIFICATE IN HAND IN ORDER TO RECEIVE CREDIT FOR A COURSE.

Name: _____ DE Nursing License Number: _____
Last First MI City State Zip

Address: _____

CONTINUING EDUCATION REQUIREMENT: (please mark appropriate box)

- I am a Licensed Practical Nurse and am required to submit 24 hours of continuing education.
 I am a Registered Nurse and am required to submit 30 hours of continuing education.

Date <small>M/D/Yr</small>	Name of course/program/conference etc. NO INITIALS	Name of Provider NO INITIALS (NOT Presenter or Approver)	Number of Contact Hours

Please note: 1 college credit = 5 contact hours

Are you enrolled in a nursing degree program? YES _____ NO _____

***** PLEASE SIGN AND DATE FORM ON REVERSE SIDE*****

Date <small>M/D/Yr</small>	Name of course/program/conference etc. NO INITIALS	Name of Provider NO INITIALS (NOT Presenter or Approver)	Number of Contact Hours

Please note: 1 college credit = 5 contact hours

Are you enrolled in a nursing degree program? YES _____ NO _____

By my signature below I certify that the information contained in this document is true and correct to the best of my knowledge.

SIGNATURE: _____

DATE:

This form may be duplicated as needed