

## APPLICATION FOR ARNP AND PRESCRIPTIVE AUTHORITY

LICENSE #

**Check all that apply:**

- Request ARNP   
  Request Prescriptive Authority   
  Request Interim Permit   
  Request Schedules II-IV

\$65 Fee must accompany application, includes Prescriptive Authority and is non-refundable. Make checks payable to Department of Health. There are 10 areas of Advance Practice that Washington State Licenses. Please check only one per application. **Note: each Advanced Practice requires an application and fee.**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Family Nurse    | <input type="checkbox"/> Nurse Midwife  | <input type="checkbox"/> Clinical Spec in Pysch/Mental | <input type="checkbox"/> Nurse Anesthetist |
| <input type="checkbox"/> Pediatric Nurse | <input type="checkbox"/> Adult Nurse    | <input type="checkbox"/> Geriatric Nurse               | <input type="checkbox"/> Acute Care Nurse  |
| <input type="checkbox"/> School Nurse    | <input type="checkbox"/> Neonatal Nurse | <input type="checkbox"/> Woman's Health Care Nurse     |  |

### 1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME		LAST	FIRST	MIDDLE NAME OR INITIAL
OTHER NAMES USED				
RESIDENCE ADDRESS				
CITY	STATE	ZIP	COUNTY	
TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.) (    )	RESIDENCE TELEPHONE (    )	SOCIAL SECURITY NUMBER (REQUIRED) -    -	DATE OF BIRTH (MONTH DAY YEAR) /    /	

- Currently nationally certified as a nurse practitioner in the area of \_\_\_\_\_  
SPECIALTY  
 by \_\_\_\_\_ on \_\_\_\_\_  
NATIONAL CERTIFYING BODY
DATE OF RECOGNITION
- Not currently certified but have registered for a board approved national examination in the area of \_\_\_\_\_  
SPECIALTY by \_\_\_\_\_  
NATIONAL CERTIFYING BODY  
 on \_\_\_\_\_  
EXAM DATE

### 2. PREVIOUS LICENSURE

List all states where any health care licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

STATE/JURISDICTION	PROFESSION	LICENSE TYPE	LICENSE		METHOD OF LICENSURE
			YEAR ISSUED	NUMBER	

### 3. AIDS EDUCATION AND TRAINING ATTESTATION

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE
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4. PERSONAL DATA

YES NO

- 1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. [ ] [ ]

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered “yes” to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered “yes” to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered “yes” to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in “1b” so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

- 2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. [ ] [ ]

“Currently” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“Chemical substances” includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

- 3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? [ ] [ ]

- 4. Are you currently engaged in the illegal use of controlled substances? [ ] [ ]

“Currently” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“Illegal use of controlled substances” means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you must answer “yes” to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

- 5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

a. the use or distribution of controlled substances or legend drugs? [ ] [ ]

b. a charge of a sex offense? [ ] [ ]

c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) [ ] [ ]

- 6. Have you ever been found in any civil, administrative or criminal proceedings to have:

a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? [ ] [ ]

b. committed any act involving moral turpitude, dishonesty or corruption? [ ] [ ]

c. violated any state or federal law or rule regulating the practice of a health care professional? [ ] [ ]

- 7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, explain and provide copies of all judgments, decisions, and agreements. [ ] [ ]

- 8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? [ ] [ ]

- 9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? [ ] [ ]

**5. EDUCATION**

List in chronological order 30 hours of pharmacology education attended by you during the past two years. Include pharmacokinetic principles and their clinical application and use of pharmacological agents in the prevention of illness, restorations, maintenance of health. \*Note: This may have been included in your NP Program. **This section only needs to be filled out if applying for Prescriptive Authority. Send in documentation of pharmacology (certificates, transcripts, etc.).**

PHARMACOKINETIC PRINCIPLES AND THEIR CLINICAL APPLICATIONS	CONTACT HOURS

**6. APPLICANT'S ATTESTATION**

I, \_\_\_\_\_, certify that I am the person described and identified in  
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and my independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my certification to practice in the State of Washington.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

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