# Colorado Division of Professions and Occupations

# Office of Licensing—Nursing

1560 Broadway, Suite 1350 Denver. CO 80202

Phone: (303) 894-7800 / Fax: (303) 894-7693 www.dora.colorado.gov/professions

#### REINSTATEMENT APPLICATION—PRACTICAL NURSE

#### APPLICANT INSTRUCTIONS

Only complete this application if your Colorado PN license is in Expired status. If your license is in Inactive status, you must complete a Reactivation application.

Nurse Licensure Compact. The Nurse Licensure Compact became effective in Colorado on October 1, 2007, allowing nurses licensed in Colorado to practice in other compact states. A nurse may hold only one compact license and it must be issued by his/her state of primary residence. If you declare your primary state of residence to be a compact state other than Colorado, you should not apply for licensure in Colorado and your application will be returned to you. Upon issuance of a Colorado multistate license, your other compact state license(s) will expire. You may be required to provide proof of residency, which may include but is not limited to a Colorado driver's license, voter registration or income tax return. If you declare a non-compact state as your state of primary residence, and you meet all other requirements for licensure in Colorado, you will receive a single-state license valid for practice only in Colorado. For a list of states participating in the Compact or for additional information about the Compact visit:

www.dora.colorado.gov/professions/nursing or https://www.ncsbn.org/nlc/htm.

**Mandatory Practice Act.** Colorado has a mandatory practice act, which means that you may not practice as a Practical Nurse in this state without a Colorado or other compact state license. Submission of this application does not guarantee licensure. Therefore, do not make life or career decisions based on the probability that you may receive a license. Plan ahead for the time it will take to receive and review all required documents and complete our evaluation.

**Basic Requirements.** Requirements for licensure are outlined in the Colorado Revised Statutes, specifically 12-38-101; the Board's rules; and the Board's policies. These documents are available online at <a href="https://www.dora.colorado.gov/professions/nursing">www.dora.colorado.gov/professions/nursing</a>.

In compliance with the Michael Skolnik Medical Transparency Act of 2010, all applicants are required to complete and maintain an online Healthcare Professions Profile on our website at <a href="https://www.dora.colorado.gov/professions/hppp">www.dora.colorado.gov/professions/hppp</a>.

**Retired Volunteer Nurse Status.** You may apply for reinstatement as a Retired Volunteer Nurse if you are at least 55 years of age and you meet the competency requirements as outlined in Board Rule 5.6. You may not accept compensation for nursing tasks performed.

**About the Application.** This application is to be completed by you and returned to the Office of Licensing. All questions on the application are mandatory, and all supporting documents must be submitted with the application. The application forms must be completed in original ink or typed. Keep a copy of the completed application and supporting documents for your records.

**Application Expiration.** Your application will be kept on file for one (1) year from the date of receipt in the Division. Your file and all supporting documentation will be purged if you do not submit required documents and complete your application process in one year. You will need to submit a new application packet and fee after that time.

Social Security Number is Required. Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit his/her Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. The affidavit is available on our website at <a href="https://www.dora.colorado.gov/professions/nursing">www.dora.colorado.gov/professions/nursing</a>, or you may call (303) 894-7800 to request that one be mailed to you.

#### **APPLICANT INSTRUCTIONS (Continued)**

**Name Change Documentation.** If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).

**Disclosure of Addresses.** Consistent with Colorado law, all addresses and phone numbers on record with the division are public record and must be provided to the public when requested. It is your responsibility to keep your address, phone numbers and contact information up-to-date in our database. All letters, renewal notices, and licenses are mailed to the last known address of record. **If your address is not current, it is possible you will not receive important documents.** You can change your address online by using Online Services at <a href="www.dora.colorado.gov/professions/onlineservices">www.dora.colorado.gov/professions/onlineservices</a>.

License Expiration Grace Period for New Applicants. Practical Nurse license expiration dates are August 31 of even-numbered years. All new applicants who are issued a license within 120 days of the upcoming renewal expiration date will be issued a license with the subsequent expiration date. For example, licenses issued between May 1, 2012 and August 31, 2012 will reflect a license expiration date of August 31, 2014. Licenses issued prior to May 1, 2012 will reflect an expiration date of August 31, 2012 and must renew in the upcoming renewal period.

Checking Your Application Status. Visit Online Services at <a href="www.dora.colorado.gov/professions/onlineservices">www.dora.colorado.gov/professions/onlineservices</a> to track your application from the date we log it in our database to the date your license is printed. Please allow us enough time to receive the application through the mail and enter your application into our database before you check the website. We recommend waiting at least 10 business days from date of mailing before checking the status of your application.

**IV Authority.** Reinstatement of your LPN license does not reinstate your IV Authority. You must submit a separate application after your LPN license is reinstated. Applications are available online at <a href="https://www.dora.colorado.gov/professions/nursing">www.dora.colorado.gov/professions/nursing</a>.

#### **APPLICANT CHECKLIST**

То арр	ly to reinstate your expired Colorado Practical Nurse license:
	<b>Complete the attached application.</b> Return the completed application and all supporting documentation to the Office of Licensing.
	Enclose the non-refundable application processing fee. See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to <i>State of Colorado</i> . All fees are non-refundable and subject to change every July 1.
	<b>Complete and return the attached Affidavit of Eligibility form.</b> Pursuant to C.R.S .24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.
	<b>Provide documentation of any name change.</b> If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).
	Complete an online Healthcare Professions Profile. Once your application is received and entered into the Division of Professions and Occupations database, you must create a Healthcare Professions Profile on our website at <a href="https://www.dora.colorado.gov/professions/hppp">www.dora.colorado.gov/professions/hppp</a> . You may begin checking the Healthcare Professions Profiling Program (HPPP) website within a few days of submitting your application. If you cannot create your profile within 14 days of submitting your application, or if you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at (303) 894-5942. <a href="Your application is not considered complete">Your application is not considered complete</a> , and a license will not be issued until you have submitted the online profile.
	If your license has been expired for more than two years or you have not practiced as a practical nurse within the two (2) year period preceding your submission of this application, you must demonstrate competency to practice. Refer to the Competency to Practice section of the application for detailed instructions.

Division of Professions and Occupations
Office of Licensing—Nursing
1560 Broadway, Suite 1350
Denver, CO 80202

Return your completed application packet and all supporting documentation to:



Lauren Larson
Director, Division of Professions and
Occupations

# IMPORTANT NOTICE

TO: All Applicants

**FROM**: Director of the Division of Professions and Occupations

**SUBJECT**: Licensure and Criminal History

Thank you for your interest in becoming a licensed\* professional within the Division of Professions and Occupations. Before you submit your application, please be aware of a few facts regarding criminal conduct, convictions, and disciplinary actions in other states.

The mission of the Division of Professions and Occupations is "public protection through effective licensure and enforcement." One way the Division safeguards consumers is by issuing licenses to fully qualified, competent, and ethical applicants.

During the licensing process – and depending on the specific application – the Division may ask whether you have ever been disciplined in any state, arrested, charged, convicted, or pled guilty to a crime. An arrest, subsequent criminal conviction, or disciplinary action is not an automatic disqualification from licensure. Rather, the appropriate board or program will look at the facts surrounding the criminal conduct and disciplinary action in addressing your license application. You should know that licensure is a privilege, not a right. One thing you must do to obtain the privilege is to be complete and accurate in disclosing information on your application.

Be sure to list all relevant complaints, disciplinary actions, arrests, charges, or convictions in response to the appropriate licensure questions. Failure to fully and accurately disclose requested criminal history information, alone, could constitute grounds for denial of your application or revocation of your license. When requested, you must include information regarding prior conduct. This remains the case when the conduct is seemingly unrelated to the activities of a profession, and when the conduct involves deferred sentences or judgments.

Remember, even following licensure, you are still required to notify your professional licensing board or program about subsequent convictions and disciplinary actions in other states.

Please be aware that the Division conducts audits of its licensing database against several criminal and national disciplinary databases. This allows the Division to verify the truthfulness of your application and track subsequent criminal and disciplinary conduct after initial licensure. Keep in mind, your license will not necessarily be revoked, or your application denied, if you have been disciplined, arrested, charged or convicted. But, you will most likely be denied or revoked if you fail to disclose requested information.

\*The word "license" is used as a general term. While most of the professions and occupations are licensed, others may be registered, certified, or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.



Colorado Department of Regulatory Agencies Division of Professions and Occupations 1560 Broadway, Suite 1350 Denver, CO 80202

## Licensee/Applicant Full Legal Name

Last			First	Middle	Suffix		
	Colorado Professional or Occupational License/Certification/Registration Number:  (if already licensed)  Professional or Occupational License/Certification/Registration type applying for:						
			AFF	IDAVIT OF ELIGIBILIT	Y		
				LL applicants for original licer required to complete and sign		ng or reinstating a	
				of the professions and occupations a profession or occupation, please co			
		Sect	ion A: LA\	WFUL PRESENCE in the Un	ited States		
1.				cceptable secure and verifiab d. Complete documentation r			
2.	to be employed	d in the U.S. Ch	neck <u>one</u> o	oresent in the U.S. and <u>authorize</u> f the acceptable secure and vicin requested. Complete doc	verifiable documents in S	ection B that	
3.	I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)  a.   I am a U.S. citizen, not physically present or employed in the United States.						
	b.   I am a Foreign National, not physically present or employed in the United States.						
		Coot	D. CE	CUDE AND VEDICIADI E DO	CLIMENTO		
	Section B: SECURE AND VERIFIABLE DOCUMENTS Select ONE document in this section if you checked 1 or 2 in Section A.						
		Name of state				Expiration	
Go	vernment Issued	or federal ag	ency that	Full name as shown on o		Date	
П	Identification Driver's license or	issued the d	ocument	license or state/federal is	sued ID Number	(mm/dd/yyyy)	
	permit						
	Government issued ID card						
	Valid U.S. military ID/common access card						
	Colorado Department of Corrections inmate ID						
	Tribal ID card						
	U.S. passport						
	Certificate of						

	Section B: SECURE	AND VERIFIABLE D	JCOINLINI 3 (COII	itiriueu <i>j</i>	
	Name of state agency				Expiration
Government Issued	or federal agency that	Full name as sho	wn on driver's	License/ID	Date
Identification	issued the document	license or state/fe	deral issued ID	Number	(mm/dd/yyyy)
Certificate of (U.S.) Citizenship					
☐ Valid Temporary Resident card					
Valid I-94 issued by Canadian government					
Valid I-94 with refugee/asylum stamp					
☐ Valid I-766 (Employ	ment Authorization Card)		Issuing federal a	agency:	
Name	on card	Alien Number (A#)	Card Number	Valid from (mm/dd/yyyy)	Expires (mm/dd/yyyy)
☐ Valid I-551 (Reside	nt Alien or Permanent Resid	dent Card)	Issuing federal a	agency:	
Name	on card	Alien Number (A#)	Country of birth	Card expires (mm/dd/yyyy)	Resident since (mm/dd/yyyy)
		,		(	(**************************************
☐ Valid foreign passp	ort with an unexpired visa w	vith proper classification	n for work authoriza	ation, and an unex	pired I-94
			Visa Class		1
Issuing foreign country	Passport Number	Visa Number	(ex.: J-1, P-1, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)
			, ,	(**************************************	(**************************************
☐ Valid foreign passp visa	ort bearing an unexpired "P	rocessed for I-551" sta	mp or with an attac	ched unexpired "Te	emporary I-551"
Issuing foreign countr	y:		Passport Number	er:	
	5	Section C: ATTESTA	TION		
<ul> <li>I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.</li> </ul>					
<ul> <li>I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the above statements are true and correct.</li> </ul>					
<ul> <li>I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.</li> </ul>					
<ul> <li>I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.</li> </ul>					
Print Full Legal Name					
Signature (Full Name)			Date		<del></del>

Division of Professions and Occupations
Office of Licensing–Nursing
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www.dora.colorado.gov/professions

Reinstatement Application PRACTICAL NURSE

Active Status Fee: \$104

Retired Volunteer Nurse Status Fee: \$20

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.							
Fees may be p	paid by check o	r money o	rder drawn i	n U.S. de	ollars on a U.S. bank a	nd made payable to	State of Colorado.
Select a licens	se status:						
□Iw	ish to reinstate w	ith full ACTI	I <b>VE</b> status. Fe	e: <b>\$104</b>			
	o be eligible for F	Retired Volui	nteer Nurse si	tatus, you	E status. Fee: <b>\$20</b> I must be 55 years of age accept compensation for		
Colorado Pra	ctical Nurse Li	cense Nu	mber:		Date Lice	ense Expired:	
			PART 1-	-APPLI	CANT INFORMATION		
Name: Last:				First:		Middle:	Suffix:
Previous Nan	ne(s):						
Social Securi	ty Number: *			Date o	f Birth (mm/dd/yyyy):	Gender:	☐ Male ☐ Female
Place of Birth	(city and state, or	foreign count	try):				
Mailing Addre	ess: me	PO Box, S City, State					
Daytime Telephone Number: ( ) E-mail Address:							
Preferred method for communication:							
PART 2—LICENSE INFORMATION							
A. Since the date your Colorado nursing license expired, have you been practicing as a Practical Nurse in the state of Colorado?							
Do you ho	ld an active Co	mpact mu	ulti-state lice	ense? I	f <b>YES</b> , provide license	information.	☐ YES ☐ NO  Have you practiced on
State	Issue D	ate	Expiration	Date	Disciplinary action against license?	Is this license current/active?	this license in the past 2 years?
					☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
					ou hold or have ever f not applicable, ente		re license. (If
Type of license	State/Country	Licens Numbe		license sued	Disciplinary action against license?	Is this license current/active?	Have you practiced on this license in the past 2 years?
					☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
					☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
					☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

<sup>\*</sup>Social Security Number Disclosure: Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's social security number. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support under § 14-14-113 and § 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation for identification purposes only. Your social security number will not be released for any other purpose not provided for by law.

APPLICANT NAME:

	PART 3—MILITARY QUESTIONS		
1.	Are you a Member of the U.S. military?		
	If YES, provide information below:	☐ YES	∐ NO
Bra	anch: Duty Station:		
2.	Are you the spouse of an active duty military member who has been relocated to Colorado and hold a currently valid and active credential to practice your profession in another state?	☐ YES	Пио
	If YES, refer to the Military Spouse Exemption Form available on our website at: www.dora.colorado.gov/professions/military.		
	PART 4—SCREENING QUESTIONS		
Yo	<ul> <li>u must provide the following for each "YES" response to the screening questions below:</li> <li>An explanation, signed and dated by you, of your behavior or practice that led to the occurrence, io Date(s) of event/offense</li> <li>Description of event/offense</li> <li>Location/court</li> <li>Current status/outcome</li> </ul>	including:	
Yo	u may be required to provide the following:		
	Copies of legal documents relating to the event/offense.		
	<ul> <li>Copies of legal documents indicating your compliance with any requirements imposed upon you.</li> </ul>		
1.	Has any nursing or other health care license held by you been denied, revoked, suspended, reprimanded, fined, surrendered, restricted, limited, or placed on probation in any state other than Colorado or in any territory of the United States?	☐ YES	□NO
2.	Are you under investigation or is a disciplinary action pending against your nursing license or other health care license in any state or territory of the United States?	YES	□NO
3.	Have you received notification from the Department of Health and Human Services, Office of the Inspector General, that you have been excluded from participation in Medicare, Medicaid or any federal health care programs based on program related crimes and discipline?	☐ YES	□NO
4.	Have you ever been convicted, entered a plea of guilty, nolo contendere, or no contest for any felony, misdemeanor or petty offense?	YES	□NO
5.	Have you ever been convicted, pled no contest/nolo contendere, or had a court accept a plea to a criminal motor vehicle offense of DUI/DWI/DWAI/OWI or any traffic offense involving drugs or alcohol?	☐ YES	□NO
6.	Has any final judgment, settlement or arbitration award for malpractice been paid by you or on your behalf?	YES	□NO
7.	In the last five years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a practical nurse safely and competently including but not limited to bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder?	YES	□NO
8.	Do you now abuse or excessively use, or have you in the last five years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a practical nurse safely and competently?	YES	□NO

APPLICANT NAME:					
PART 4—SCREENING QUESTIONS (Continued)					
9. Have you been terminated or permitted to resign in lieu of termination from a nursing or other health YES NO care position because of your use of alcohol or use of any controlled substance, habit-forming drug, prescription medication, or drugs having similar effects?					
10. Have you been arrested for an alcohol or drug-related offense other than stated in question No. 5?	0				
PART 5—DECLARATION OF PRIMARY STATE OF RESIDENCE					
"Primary State of Residence" is defined as the state of a person's declared fixed permanent and principal home for legal purposes; domicile. Documentation of primary state of residence that may be requested will include but is not limited to:					
<ul> <li>a. Driver's license with a home address;</li> <li>b. Voter registration card displaying a home address;</li> <li>c. Federal income tax return declaring the primary state of residence;</li> <li>d. Military Form no. 2058 - state of legal residence certificate; or</li> <li>e. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence. (Statutory basis: Articles 2E, 4C, and 4D)</li> </ul>					
Based on the information above, I declare that the state of is my legal primary state o residence.	,f				
My primary state of residence is currently in another compact state and I am in the process of moving to Colorado. I understand that in order to complete the licensure process, I must provide proof of Colorado residency and a physical address after establishing Colorado residency.					
Primary Residence Physical Address: (PO Boxes are not accepted)  Street: City, State, Zip:					
PART 6—DECLARATION OF STATE(S) OF CURRENT PRACTICE					
Upon licensure in Colorado, I may practice in the state(s) of (Attach additional sheets if necessary):					
Colorado (strike through if not applicable)					
☐ I will practice exclusively at a government / military facility and am requesting a Colorado single-state license.					
PART 7—COMPETENCY TO PRACTICE					
Has your Colorado license been expired more than two (2) years?					
NO. I <u>HAVE</u> practiced nursing within the two (2) year period preceding submission of this application. Part 7 complete. Sign, date, and submit your application to the Office of Licensing.	is				
complete. Sign, date, and submit your application to the office of Licensing.	ĺ				
NO. I <u>HAVE NOT</u> practiced nursing within the two (2) year period preceding submission of this application. You must demonstrate competency by checking Option B below and following the corresponding instructions.					
NO. I <u>HAVE NOT</u> practiced nursing within the two (2) year period preceding submission of this application.					

#### **APPLICANT NAME:**

### PART 7—COMPETENCY TO PRACTICE (Continued)

This section - and all attached forms referenced in this section - applies only to individuals whose license has been
expired for more than two (2) years or who has not practiced nursing within the two (2) year period preceding
submission of this application. Competency to practice may be established by one of the following methods:

#### Check either Option A or Option B

- **A.** Demonstration of the active practice of nursing in another state, federal facility, or U.S. territory during the two (2) years preceding the filing of this reinstatement application. If you select this option, you are attesting that you have worked during the two (2) years preceding the submission of this application and you must submit the following with your application:
  - Verification of Active Licensure. Contact the state in which you hold an active license or a license that has been expired less than two (2) years, to determine their fee and which of the verification forms you need to submit.
    - For participating states, you must apply for NURSYS verification through the NURSYS website (a current list of participating states can be found at <a href="https://www.nursys.com">www.nursys.com</a>) —OR—
    - For non-participating states, you must complete and submit a Request for Verification of Nursing License form (attached).

This process may take anywhere from two weeks to several months, depending on your circumstances and how quickly you submit the supporting documentation required. You can help speed this process by completing the application thoroughly, supplying all the required supporting documents, and responding quickly to requests for information made by staff.

#### —OR—

- **B.** Successfully completing refresher courses as defined in Nursing Board Rule 5.6. If you select this option, <u>you must</u> complete all three of the following steps:
  - 1. Register for a Board-approved nursing education program / refresher course.
  - 2. Within the guidelines of your chosen program / course, locate a qualified clinical agency (acute, subacute, skilled) to obtain the required, unpaid supervised clinical experience. Submit a completed Non-Traditional/Refresher Program Instructor/Preceptor Agreement (attached) with your application and fee to the Office of Licensing, 1560 Broadway, Suite 1350, Denver, CO 80202.

Upon review and approval of the application and Non-Traditional/Refresher Program Instructor/Preceptor Agreement, your license will be reinstated in a Restricted Status, valid only for the purpose of completing the clinical experience. Plan ahead for the time it will take to receive and review all required documents and complete our evaluation.

#### This process must be completed prior to the start of the clinical training.

- 3. Upon completion of steps 1 and 2 above, provide evidence of having completed all requirements as follows:
  - Obtain an official transcript or certificate in its official sealed envelope indicating completion of the Boardapproved nursing education program/refresher course;
  - Obtain an original completed Non-Traditional/Refresher Program Skills Checklist (attached) from your Preceptor in an official sealed envelope; and
  - Submit both documents in their unopened, sealed envelopes to the Office of Licensing.

Upon review and approval of both documents, the restriction will be removed from your license and a new license copy will be issued in an Active or Retired Volunteer Status, as appropriate, if all other licensing requirements are met.

#### **ATTESTATION**

I state under penalty of perjury in the second degree, as defined in C.R.S. 18-8-503, that the information contained in this application is true and correct to the best of my knowledge. In accordance with C.R.S. 18-8-501(2)(a)(I), false statements made herein are punishable by law and may constitute violation of the practice act.

Applicant Signature	Date
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### USE THIS FORM IF YOUR STATE OF LICENSURE IS NOT LISTED WITH NCSBN/NURSYS

For a list of NURSYS participating states, please see www.nursys.com

Colorado Division of Professions and Occupations

### Office of Licensing-Nursing

1560 Broadway, Suite 1350 Denver, CO 80202

Phone: (303) 894-7800 / Fax: (303) 894-7693 www.dora.colorado.gov/professions

### REQUEST FOR VERIFICATION OF NURSING LICENSE

You are responsible for ensuring your state of licensure sends verification to the Colorado Office of Licensing. You are also responsible for ensuring its receipt by the Colorado Office of Licensing.

d by the APPLICANT and forwarded to state of active licensure with f

Last Name		First			Middle
Previous Name(s)					
Mailing Address (F	PO Box, Street, City, State	, & ZIP)			
Social Security Nu	ımber		Date of Birt	h	
Licensed under the	e name of	Year of	License		Original license number
I hereby	authorize all Boards o	of Nursing to release m	ny license data to t	he Colorado	Board of Nursing.
Applicant Signatur	re			ite	
		NSING BOARD of the			sent to the Colorado (
of Lice		er inc	State of abilite not		chi to the colorado (
icensed by Exam	:	State Board	Evam	NCLEX	
		PN	Exam	PN	
	Score				
	Series/Form				
icensed by Endo	rsement: State:				
Active License/	Registration Number		Date Issued		License Expiration Date
as any disciplinary	action EVER been taken	against this license?	☐ YES	□NO	
► If YES,	please send certified copi	es of all disciplinary action	S.		
s license now in go	od standing?		☐ YES	□NO	
<b>▶</b> If <b>NO</b> , p	lease attach documentation	on.			
(Board Se	eal)	Signature			Title
		Board of Nursing / State	7		Date

# NON-TRADITIONAL / REFRESHER PROGRAM INSTRUCTOR / PRECEPTOR AGREEMENT All information requested in this form must be provided

	All information requested in this fo	rm must be provided
Ctudent Nema (print legible)		Colorada Liganaa Numbar
Student Name (print legibly)		Colorado License Number
the purpose of providing clinic Policy 10-03, which is incorpo- pursuant to section 3.4 of the	al experience to Student pursuant rated herein by reference. See wa Board's Chapter I – Rules and Re	ceptor, Faculty*, and Facility, is entered into for to Colorado State Board of Nursing ("BON") www.dora.state.co.us/nursing/policies/policies, and gulations for the Licensure of Practical and parties, whose information is fully set forth below
instructor directly overseeing Instructor/Preceptor agrees to Program Skills Checklist" and clinical portion of the refreshe	a small group of students —OR— ( evaluate Student's performance p to provide student with the require r/remedial course. In addition, Inst al Non-Traditional/Refresher Progr	bical supervision in a traditional format with one <b>B)</b> direct supervision of student on a 1:1 basis. Sursuant to the BON "Non-Traditional/Refresher devaluation upon Student's completion of the ructor/Preceptor will provide official am Skills Checklist in an official sealed envelop
<ul> <li>NOTE: Instructor signs the Skills C</li> </ul>		must be the same instructor/preceptor who
Faculty* agrees that its re official documentation as requ		etical and didactic course work to the Student in
Facility agrees that the cl	inical instruction required herein m	ay be provided at its facility.
	<b>LETING THIS FORM</b> : Applicants I by your Instructor/Preceptor below	applying for PN reinstatement should have w:
1. Instructor/Preceptor:	denoted Denoted by a large transfer	- Date
Printed Name:	structor/Preceptor signature	Date
Title/Position:		Phone number:
License No(s): RN	PN	Status of License(s):
State(s) licensed:	Year(s) Issued:	Exp. date(s):
Educational degrees:		Yrs. clinical experience:

Schools attended & years graduated:

2. Faculty:		
Faculty member signature		Date
Printed name of school:		
Address of school:		
Printed name of faculty member:		
Title:	E-mail address:	
Phone number:	Fax number:	
3. Facility:Facility representative signa	ature	Date
Printed name of facility:		
Address of facility:		
Facility provides (circle all that apply): acute	e care sub acute care	skilled nursing
Printed name of facility representative:		
Title:	E-mail address:	
Phone number:		
All Applicants must sign and date the form be	low:	
4. Student:		
Student signature		Date

<sup>\*</sup> Faculty: Individuals meeting the requirements of the rules, designated by the governing body as having ongoing responsibility for curriculum development, planning, teaching, guiding, monitoring, and evaluating student learning in the classroom and practice setting.

# NON-TRADITIONAL / REFRESHER PROGRAM Skills Checklist

Student	Social Security Number
Program	
Instructor/ Preceptor	
Clinical Supervision Start Date	End Date

> Please mark each competency as 'Satisfactory', 'Needs Improvement', OR 'Not Observed'

> Note: All clinical competencies must be observed

Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
PN Provider Role				
Performs services under the supervision of a registered nurse, physician, dentist or podiatrist.				
Performs and accurately collects basic health assessment data on patients contributing to the comprehensive patient assessment.				
Identifies common needs and problems, recognizes normal from abnormal findings and reports changes in findings to the appropriate health care professional.				
Contributes to the nursing plan of care.				
Provides basic care to those patients with predictable outcomes.				
Administers treatments, including medications as prescribed within the plan of care. Includes the medical plan of care and the nursing plan of care and:				
<ul> <li>Has accurate knowledge of the treatment procedure, and expected outcome.</li> </ul>				
<ul> <li>Is skilled in safely administering the treatments.</li> </ul>				
<ul> <li>Administers the right treatment to the right patient, at the right time.</li> </ul>				
Documents accurately and in a timely manner.				
Communicates to appropriate authority in a timely manner if patient refuses treatment, error is made, or an unpredicted event occurs.				
Uses technology, information and facility resources appropriately and effectively.				
Communicates in an accurate, clear and respectful manner with patients, families, supervisors and other Health Care Providers.				

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Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
Develops and maintains appropriate relationships	Jansiaciory	improvement	Not Observed	IIIIIIII
with patients, families, colleagues, and other health care professionals.				
Participates in the evaluation of patient outcomes and implementing necessary change.				
Assists in the formation of a teaching plan based on the needs of the patient.				
Supports and reinforces teaching as prescribed in the plan of care.				
Reports changes in individual / family / group condition in a timely manner and to the appropriate supervisor.				
PN Professional Role				
Is current in knowledge of illness care and treatment trends.				
Promotes patient safety.				
Is a safe practitioner that practices within the PN scope of practice				
Maintains patient confidentiality.				
Protects self and patients through safe practices such as universal precautions, lifting guidelines, and self-care practices.				
When directed coordinates, organizes and prioritizes care provided for the patient.				
Assigns care appropriately.				
Monitors care provided by assignees.				
Offers feedback to assignees on care provided.				
Uses effective communication and conflict management skills.				
Promotes teamwork.				
Hours of Clinical Provided	Clinical hours Documented	Needs More Hours	Recommended Additional Hours	Preceptor Initials
120 hours required for applicants with license expired over 10 years with possible additional hours determined by Board				
120 hours required for applicants with license expired 6 and up to 10 years				
80 hours required for applicants with license expired 2-5 years				

<sup>\*</sup>All clinical competencies must be observed. If competencies are marked "needs improvement," or "not observed," document on a separate sheet of paper the specifics of what you believe the applicant needs to be successful for each competency that is marked.

NOTE: Instructor/Preceptor who signs this Skills Checklist and initials the "Preceptor Initials" column must be the same Instructor/Preceptor who signed the Non-Traditional/Refresher Program Preceptor Agreement.

Attestation	
I affirm that the clinical experience described on this form was conducted and completed in accompleted in accompleted in accompleted by the clinical state Board of Nursing Rule 5.6 for Refresher Applicants. I further affirm that the clinical was completed under my supervision.	
I declare under penalty of perjury in the second degree that the statements made herein are true and comof my knowledge.	nplete to the best
Printed Name and Address of Instructor/Preceptor:	
Daytime Contact Telephone Number of Instructor/Preceptor:	
Colorado License Number:	
Instructor/Preceptor Signature:	
	Date Signed
Student Signature:	
	Date Signed
Instructor/Preceptor should provide the original Skills Checklist in an official sealed envelope to submission to the State Board of Nursing:	the student for

APPLICANT NAME:

Division of Professions and Occupations

Office of Licensing—Nursing

1560 Broadway, Suite 1350

Denver, CO 80202