

IOWA BOARD OF NURSING
400 SW 8th St., Suite B
Des Moines, IA 50309-4685



**APPLICATION FOR LICENSE BY ENDORSEMENT
LICENSED PRACTICAL NURSE -
REGISTERED NURSE**

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.

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

1. I am applying for License by Endorsement for a:

- Licensed Practical Nurse
 Registered Nurse

SECTION A - PERSONAL INFORMATION

**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. Alternate Phone Number
13. E-Mail Address
14. Social Security #
15. Date of Birth
16. Are you a Veteran? Yes No
17. Are you a Spouse of a Veteran? Yes No

18. Gender

- Female
- Male

19. Race/Ethnicity

- | | |
|---|---|
| <input type="checkbox"/> White, Caucasian | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> Black, African American | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Multi-Racial |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other |

SECTION B- APPLICANT INFORMATION

1. Have you ever held a license in Iowa?

- Yes If Yes, RN License number(s)
 No LPN (if known)

2. In what state were you ORIGINALLY LICENSED by examination for this license type?

State License Number (if known)

3. In what other state(s) have you held any level of nursing license. State(s)

4. If applying for an LPN license in Iowa, did you graduate from an LPN Program?

- Yes
- No

5. Were you originally licensed in a country outside of the United States.?

- Yes
- No

6. Have you passed the licensing examination in the United States?

- Yes
- No

7. If Yes to Questions 5 & 6, has the Commission of Graduates of Foreign Nursing Schools completed the Full Education Course by Course Report (Professional Report) for PN and RN Applicants or issued a certificate letter?

- Yes Date Report submitted to the Iowa Board of Nursing
 No

8. Date Transcript was requested from your Nursing Education Program.

mm/dd/yyyy

9. Date applied for Original License Verification online through NURSYS.COM or date Verification Form and fee was sent to your original state of license if not a NURSYS participant. (see instructions for participating states) mm/dd/yyyy

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 is 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)

- If you declare IOWA as your primary state of residence, you will be issued an Iowa multi-state license, which will allow you to practice in ANY other compact state.
- If you declare ANOTHER compact state as your primary state of residence you cannot be licensed in Iowa unless you are employed by the federal government or in the military.
- If you declare a non-compact state as your primary state of residence, you will be issued an Iowa single-state license which authorizes you to practice only in Iowa.

10. My Current Primary State of Residence is:

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

SECTION C – DEMOGRAPHICS

1. Graduation from High School or GED?

- Yes
- No

2. Entry Level Education What type of nursing degree/credential qualified you for your first U.S. nursing license? (If applying for RN license choose the entry level education for your first RN license.)

- | | |
|---|--|
| <input type="checkbox"/> Vocational/Practical Certificate | <input type="checkbox"/> Master’s Degree |
| <input type="checkbox"/> Diploma (RN Only) | <input type="checkbox"/> Doctoral Degree |
| <input type="checkbox"/> Associate Degree | <input type="checkbox"/> Other |
| <input type="checkbox"/> Baccalaureate Degree | |

3. Highest Level of Education What is your highest level of education?

- | | |
|---|---|
| <input type="checkbox"/> Vocational/Practical Certificate-Nursing | <input type="checkbox"/> Master’s Degree-Nursing |
| <input type="checkbox"/> Diploma-Nursing (RN Only) | <input type="checkbox"/> Master’s Degree-Non-Nursing |
| <input type="checkbox"/> Associate Degree-Nursing | <input type="checkbox"/> Doctoral Degree-Nursing (PhD) |
| <input type="checkbox"/> Associate Degree-Non-Nursing | <input type="checkbox"/> Doctoral Degree-Nursing Practice (DNP) |
| <input type="checkbox"/> Baccalaureate Degree-Nursing | <input type="checkbox"/> Doctoral Degree-Nursing Other |
| <input type="checkbox"/> Baccalaureate Degree-Non-Nursing | <input type="checkbox"/> Doctoral Degree-Non-Nursing |

4. Name of Nursing School Attended (Program which qualified you to sit for the licensing exam)

5. School Location (City & State)

6. Date of Graduation (mm/dd/yyyy)

SECTION D - 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 Endorsement 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 state(s) and submit board documentation

SECTION E – 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 F - 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?

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

- 4. Primary Employer Name
- 5. Primary Employer State Zip Code
- 6. Primary Employer County Name County Number (if known)
- 7. Primary Employer Phone Number

8. What is your primary employment status?

- Full-time
- Part-time
- Per Diem

9. Average Hours you will work in a nursing position per week.

- <10
- 10-20
- 21-30
- 31-40
- 41-50
- >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.

10. In your employment/self-employment as a RN or LPN, will you examine, attend, counsel, or treat children or dependent adults in Iowa on a regular basis?

- Yes
- No

SECTION F - 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 J & K**)

- 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 G - EMPLOYMENT SETTING

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

- | | |
|--|--|
| <input type="checkbox"/> Academic Setting | <input type="checkbox"/> Insurance Claims/Benefits |
| <input type="checkbox"/> Community Health | <input type="checkbox"/> Long Term Care/Extended Care/Assisted Living Facility |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Office/Clinic/Ambulatory Care Setting |
| <input type="checkbox"/> Hospital | |

- Other
- Policy/Planning/Regulatory/Licensing Agency

- Public Health
- School Health Service

SECTION H - EMPLOYMENT POSITION

1. Please identify the position title that will most closely correspond 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 I - EMPLOYMENT SPECIALTY

1. Please identify the employment specialty that will most closely correspond 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 J – FEES

1. \$169.00 (Includes the \$50.00 fee to conduct the DCI and FBI criminal history background check)

SECTION K – 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 _____