



Registered Nurse Endorsement Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send supporting documents not mailed with the initial application to:

Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

Contact us:

360-236-4700

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Application Instructions Checklist

FBI background check information: Washington State Law authorizes the Department of Health to obtain fingerprint background checks for licensing purposes. This check is done through the Washington State Patrol and the Federal Bureau of Investigation (FBI).

- You **will** be required to submit fingerprints for the background check if you have an out of state address listed on this application. (Not out of country).
- You **must** obtain your fingerprints on the Department of Health fingerprint card.
- Once we receive your application **we will send** you the fingerprint packet with instructions on how to complete the process.
- A temporary practice permit will be issued if all other licensing requirements are met pending the completion of this process.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

Application Fee. This fee is non-refundable. You can check the online [fee page](#) for current fees.

1. Demographic Information:

Social Security Number: You must list your social security number on your application. If you do not have a social security number please read, complete, and return this [form](#) with your application.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle and, last.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax and Cell Numbers: List your phone, fax and cell numbers.

Email: Provide your email address. **Email is our primary form of communication.** Your email address is required. Join our [Listserv](#) to receive updates and news from the Nursing Commission.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

2. Personal Data Questions:

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide certified documentation referencing the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You may obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction refers to any other country, state, federal territory, or military authority.

3. Professional Education:

List your current or completed nursing program. Indicate degree/certificate/diploma earned. List graduation or anticipated graduation date. Attach additional completed pages if you need more space.

4. License in Other State(s) or Country(ies):

List all states/countries where you have held an RN or an LPN license. Indicate method of licensure by examination or endorsement.

5. AIDS Education and Training Attestation:

Read the AIDS education and training attestation. AIDS training may include self-study courses or formal training. If you have met the requirements on the application, or if your nursing education was after 1991, **initial and date this section without any further training**. Course content can be found in [WAC 246-12-270](#).

6. Applicant’s Attestation:

You must sign and date your application for it to be valid. Your signature indicates that you have read and understood this section. Your signature must be **original**. We will not accept the application if your signature is photocopied or has an electronic signature.

Please note: If we require additional documentation, we will notify you by email.

- The application is incomplete if requested information is left blank. Fill in N/A or place a line through the section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See [WAC 246-12-020\(3\)](#).
- Please review [continued competency requirements](#) for renewal.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at [the military resources page](#) and include supporting documentation with your application.

Registered Nurse License Requirements by Endorsement

1. RN License (verification of license by examination)

You must visit www.nursys.com and follow their directions to verify your original license by examination to Washington. There is a fee you will pay to NURSYS® for this service.

Note: To ensure no delays, please have this completed prior to sending your application.

If your original state of license does not participate with NURSYS®, send the Non-NURSYS verification form in this application packet to that Board of Nursing. Request they complete the form and send it directly back to our office. Contact their Board of Nursing to determine if there is a processing fee and where to submit this form.

2. Verification of Education

If your nursing education cannot be verified from your original state of license on NURSYS® or on our Non- NURSYS license verification form, transcripts will be required. The transcripts will need to be sent directly from your school of nursing or from another state board of nursing directly to our office. If you were educated outside the United States, transcripts are required as well. Also, please follow the directions on the education verification page to have your school of nursing complete and send to our office.

3. English Proficiency Exam

All applicants who graduated from nursing school outside the United States, other than Canada, Ireland, United Kingdom, Australia, New Zealand, and common wealth Caribbean, must take and pass either the Test of English as a Foreign Language (TOEFL) www.toefl.com or International English Language Testing System (IELTS, academic version) www.ielts.org. Exam is required regardless of whether the program was taught in English.

- Passing TOEFL scores for RN applicants are a total score of 83 with a speaking score of 26.
- Passing IELTS scores for RN applicants are a total score of 6.5 with a score of 6.0 in the following areas; listening, reading, writing, and speaking.

For applicants educated in countries not listed above and who can provide proof of working as a Registered Nurse in another U.S. State for 1,000 hours or more may have the English proficiency exam waived. Should you want this requirement waived based on employment, please have the current or past US employer submit a letter on letterhead paper confirming your employment of 1,000 hours worked sent directly to our office.

4. Proof of a current/active RN License

If your license from your original state is not current or active, we will need proof of a current or active license. If you have an active license from a state that participates with NURSYS®, we can obtain license information. If you do not have a current or active license with a NURSYS® participating state, visit the state website where your license is active, print the page showing a current or active license, and send with your application.

5. NCLEX

If you obtained your nurse education outside the United States, Washington State requires you to pass the United States national exam, the NCLEX-RN. If you do not have a license in another state or you have not taken the NCLEX-RN exam, please visit our [webite](#) for the correct application.

Date
Stamp
Here

Revenue 0258010000

Registered Nurse License Application

You must check the appropriate box: Examination Endorsement

1. Demographic Information

Social Security Number (SSN)
(If you do not have a SSN, see instructions)

National Provider Identifier Number (NPI)
(Enter 10 digit number)

Male
 Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City State Country

Address

City State Zip Code County

Country

Phone (enter 10 digit #) Fax (enter 10 digit #) Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City State Zip Code County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? Yes No
If yes, list name(s):

Will documents be received in another name? Yes No
If yes, list name(s):

For Office Use Only

COC Received
Review for: FBI HIPBB WSP PDQ NOD
 Approved per policy A21.05 delegated decision making for selected license applications
 Forward to CMT Approved by CMT Denied by CMT

Proceed with licensing process _____
Signature Date

2. Personal Data Questions

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 attach explanation.....

“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, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

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

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

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

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

- b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?

6. Have you ever been found in any civil, administrative or criminal proceeding 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?
 - b. Diverted controlled substances or legend drugs?
 - c. Violated any drug law?
 - d. Prescribed controlled substances for yourself?
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", please attach an explanation 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?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. 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?
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?

3. Professional Education

Current or Completed Nursing Program	Location of Nursing Program	Anticipated Graduation Date	Certificate/Diploma/Degree Granted
			<input type="checkbox"/> ADN
			<input type="checkbox"/> BSN
			<input type="checkbox"/> MSN
			<input type="checkbox"/> RN Diploma
			<input type="checkbox"/> PN Cert/dip
			<input type="checkbox"/> Other

4. License(s) in Other State(s) or Country(ies)

List all states/countries you have held a nurse license.

Check One		State/Country	Current Expiration Date	Method of Licensure	
As RN	As LPN			Exam	Endorsement

State in which originally licensed by examination. _____
(NCLEX or SBTPE)

Which test did you take: State Board Test Pool Examination SBTPE NCLEX None

Year initial license was first issued as a Registered Nurse: _____.

Have you ever applied for licensure in Washington prior to this application? Yes No

If yes, under the name of _____ as an RN LPN. Approximate date _____.

5. 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. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues confidentiality, psychosocial issues, and special population considerations.

If you have met the requirements, you must initial and date this section.

I understand I must maintain records documenting education for two years and be prepared to submit those records to the department if requested. **I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date
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6. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)

Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated: _____ in _____
(mm/dd/yyyy) (City, State)

By: _____
(Original signature of applicant)

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Washington State Department of
Health
 Nursing Commission
 PO Box 47864
 Olympia, WA 98504-7864
 360-236-4703

Non-NURSYS® License

Verification From U.S. of Original License

Please complete the top portion of this form and forward to your **original** state of license **if** your state does not participate with NURSYS®. (Please contact your original state of license for fee and processing time.)

Check One Box: <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical Nurse			
Name	Last	First	Middle Initial
Social Security Number (If you do not have a social security number, see instructions)		Previous last name used	
Address			
City	State	Zip Code	County
Name as it appears on original license		Original State of License	License Number
I hereby authorize the release of my license data to the Washington State Nursing Commission.			
Signature _____		Date _____	
This portion to be completed by original state of license and mailed to the above address.			
This is to certify that _____ was issued license number _____			
on _____ to practice as <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical Nurse (Vocational Nurse).			
Licensed by: <input type="checkbox"/> Exam <input type="checkbox"/> Endorsement <input type="checkbox"/> Other (specify)			
Current License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed			Expiration Date
Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach explanation)			
Disciplinary action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach explanation)			
Name of Nursing School Completed:			
Location (City and State):			
Type of Nursing Program: <input type="checkbox"/> Diploma <input type="checkbox"/> BSN <input type="checkbox"/> ADN <input type="checkbox"/> LPN <input type="checkbox"/> Other (specify)			Date of Completion
Examination Scores: State Board Test Pool Exam			
	Score	Series	
Medical	_____	_____	
Psychiatric	_____	_____	
Obstetric	_____	_____	
Surgical	_____	_____	
Nursing of Child	_____	_____	
LPN/VN	_____	_____	
NCLEX Exam:			
		RN _____	Date _____
		LPN _____	Date _____
Signature		State	Date

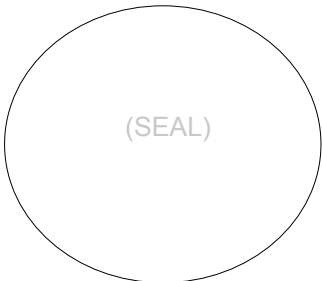
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Washington State Department of
Health
 Nursing Care Quality Assurance Commission
 PO Box 47864
 Olympia, WA 98504-7864
 360-236-4703

Education Verification for Registered Nurse Educated Outside the United States

Applicant: Complete this section and mail to your school of nursing which you graduated.

Name	Last	First	Middle Initial
Date of Birth (mm/dd/yyyy)		Other names used	
Address			
City	State	Zip Code	County
High School Graduate <input type="checkbox"/> Yes <input type="checkbox"/> No			Social Security Number
If no, GED? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I hereby request this verification be completed and a transcript mailed to the Nursing Commission			
Signature of Applicant			Date
To be completed by the Chief Administrative Officer of the school of nursing from which the above named applicant graduated, certifying the following:			
Record name of graduate _____			
Name of Nursing School _____			
Location _____			
School approved by _____ School accredited by _____			
Date student enter program _____ Graduation/completion date _____			
Diploma/Degree earned by Student _____			
Please attach an official transcript (record of all subjects taken, including hour of class and weeks of clinical experience) for this applicant. This document must carry the school seal or stamp and signature of the chief administrator officer. Note: Please complete both sides			
 <p>(SEAL)</p>		Signature _____	
		Title _____	
		Date _____	

Please respond to each item listed subject matter for Registered Nurse program:
(some subjects matter may be integrated into fundamentals of other courses)

1. Subject Matter	Completed	Not Completed
a. Anatomy and Physiology (two terms with labs).....	<input type="checkbox"/>	<input type="checkbox"/>
b. Physics	<input type="checkbox"/>	<input type="checkbox"/>
c. Chemistry.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Pharmacology.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Nutrition	<input type="checkbox"/>	<input type="checkbox"/>
f. Communication.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Computations	<input type="checkbox"/>	<input type="checkbox"/>
2. Clinical Experience		
a. Medical Nursing.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Surgical Nursing	<input type="checkbox"/>	<input type="checkbox"/>
c. Obstetrics Nursing (pre and post partum care).....	<input type="checkbox"/>	<input type="checkbox"/>
d. Post partum care of newborns.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Pediatric nursing (well and ill).....	<input type="checkbox"/>	<input type="checkbox"/>
f. Geriatric nursing	<input type="checkbox"/>	<input type="checkbox"/>
g. Psychiatric/mental health Nursing	<input type="checkbox"/>	<input type="checkbox"/>

Return to the address listed on page 1 of this form.

RCW/WAC and Online Web Site Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Unprofessional Conduct, RCW 18.130.180](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Nursing Care Laws, RCW 18.79](#)

[Nursing Care Rules, WAC 246-840](#)

[License by Interstate Endorsement, WAC 246-840-090](#)

[Continuing Competency, WAC 240-840-201](#)

On-Line

[AIDS Training Resources, Reference Page](#)

[Nursing Commission, Web Page](#)