

**OKLAHOMA BOARD OF NURSING**

2915 N. Classen Blvd., Suite 524  
Oklahoma City, OK. 73106  
(405)962-1800

**FOR OFFICE USE ONLY:**

Cert.#: \_\_\_\_\_  
Biennial#: \_\_\_\_\_  
Regis. Date: \_\_\_\_\_  
Exam Required: \_\_\_\_\_  
Approved By: \_\_\_\_\_  
Endorsed From: \_\_\_\_\_

**TYPE OR PRINT IN BLACK INK ONLY**

**APPLICATION FOR LICENSURE BY ENDORSEMENT**

RN \_\_\_\_\_ LPN \_\_\_\_\_  
FEMALE \_\_\_\_\_ MALE \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Temporary License Requested: Yes \_\_\_ No \_\_\_  
Advanced Practice Nurse: Yes \_\_\_ No \_\_\_  
(ARNPs, CNMs, CNSs, and CRNAs must submit an  
*Application for Advanced Practice Recognition* in  
addition to the endorsement application).

**I hereby make application for licensure as a Registered Nurse/Licensed Practical Nurse in accordance with the statutes of the State of Oklahoma (59 O.S. 567.1-567.17).**

- My Full name is \_\_\_\_\_  
First Middle Maiden (if applicable) Last
- Name to appear on license: (3 Full Names) \_\_\_\_\_
- Mailing address is \_\_\_\_\_  
Box Number / Street Address ( )  
City/State Zip Telephone Number
- Birth Date \_\_\_\_\_ Place of Birth \_\_\_\_\_ Email Address \_\_\_\_\_  
Mo/Day/Yr City/State
- High School Name \_\_\_\_\_ Location \_\_\_\_\_  
Date of high school graduation \_\_\_\_\_ (or) Date of GED \_\_\_\_\_
- Name and location of nursing education program from which you **graduated** \_\_\_\_\_  
Type of Program: PN \_\_\_ Associate Degree \_\_\_ Diploma \_\_\_ Bachelor's Degree \_\_\_  
Date of entering program \_\_\_\_\_ Date of Completing program \_\_\_\_\_
- State/Country of **Original** licensure \_\_\_\_\_ Original License No. \_\_\_\_\_
- Have you ever been licensed in Oklahoma? Yes \_\_\_ No \_\_\_ (If yes, check one) \_\_\_ RN \_\_\_ LPN
- Other states in which you are or have been licensed: State \_\_\_\_\_ Number \_\_\_\_\_  
State \_\_\_\_\_ Number \_\_\_\_\_ State \_\_\_\_\_ Number \_\_\_\_\_  
List other last names under which you have been licensed \_\_\_\_\_
- Are you currently practicing as a RN/LPN in Oklahoma? Yes \_\_\_ No \_\_\_  
If yes, give name and address of employer: \_\_\_\_\_
- List name and address of last nursing employer, your position title and dates of employment.  
\_\_\_\_\_

**Verification of Continuing Qualifications for Practice**

I verify that I have maintained continued qualifications for practice through completion of one or more of the following (Check all of the following that apply. You must submit the requested documentation in order for your application to be considered):

- I have completed a refresher course within the last two years with content consistent with Board policy. **(Please request that the institution offering the Oklahoma Board of Nursing approved refresher course submit an official transcript or certificate of completion.)**
- I want to take the National Council Licensure Examination. Please send me a registration form. I understand that my application will not be processed until the examination is successfully passed.
- I have completed at least seven (7) academic semester credit hours (or 105 contact hours, for LPNs enrolled in practical nursing) of nursing courses within the last two years which include classroom and clinical instruction. **(Please request that the educational institution submit an official transcript to the Oklahoma Board of Nursing.)**
- I am licensed in another state and have been employed in that state in a position requiring nursing licensure for a minimum of 520 work hours in the past two years. **(Please request that an *Employment Verification Form* be completed by your employer and submitted directly to the Board office.)**
- I have taken the NCLEX examination within the last two years. I understand that Oklahoma requires completion of the nursing education program within two years of initial application for licensure by examination or at least six months work experience in the state of original licensure. **(If you took the NCLEX examination within the last two years, please request that either an official transcript be submitted from your nursing education program or an *Employment Verification Form* be completed and submitted directly to the Board office by your employer.)**

12. **Citizenship/Immigration Status:** U.S. Citizen (check one)      Yes \_\_\_\_\_ No \_\_\_\_\_

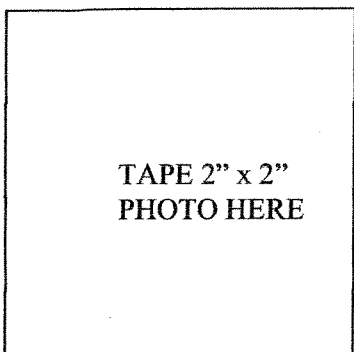
**Federal law limits issuance of professional licenses, registrations, and limited permits to United States citizens or qualified aliens. Questions about your immigration status should be directed to the Bureau of Citizenship and Immigration Services (BCIS) at 1-800-375-5283. If you are not a U.S. citizen, check the appropriate box below to indicate your immigration status.**

<ul style="list-style-type: none"> <li><input type="checkbox"/> An alien lawfully admitted for permanent residence in the United States.</li> <li><input type="checkbox"/> An alien granted asylum under Section 208 of the Immigration and Nationality Act.</li> <li><input type="checkbox"/> A refugee granted asylum under Section 207 of the Immigration and Nationality Act.</li> <li><input type="checkbox"/> An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least one year.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> An alien whose deportation is being withheld under Section 243 (h) of the Immigration and Nationality Act.</li> <li><input type="checkbox"/> An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.</li> <li><input type="checkbox"/> Non-immigrant (Temporarily in U.S.): Please list Visa type or immigration status or attach a copy of your passport if you are not required to have a Visa to enter the U.S. _____</li> </ul>
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**If you checked any of the categories listed above, enter your alien registration number or control number issued by the Bureau of Citizenship and Immigration Services: \_\_\_\_\_**  
(BCIS Number)

13. Have you ever been arrested for any offense in any state, territory, or country, including expunged offenses, with the exception of minor traffic violations, not previously reported in writing to this Board? (Minor traffic violations do not include DUI.) Yes \_\_\_\_\_ No \_\_\_\_\_
14. Have you ever been convicted of any offense in any state, territory, or country, including expunged offenses, with the exception of minor traffic violations, not previously reported in writing to this Board? Yes \_\_\_\_\_ No \_\_\_\_\_
15. Have you ever received a deferred sentence, for any offense in any state, territory, or country, including expunged offenses, not previously reported in writing to this Board? Yes \_\_\_\_\_ No \_\_\_\_\_
16. Have you ever been convicted of a felony in any state, territory, or country, not previously reported in writing to this Board? Yes \_\_\_\_\_ No \_\_\_\_\_
17. Have you ever had disciplinary action taken against your nursing license, recognition, or certificate; any health-related license, recognition, or certificate; or any application for a nursing or health-related license, recognition, or certificate in any state, territory or country, not previously reported in writing to this Board? Yes \_\_\_\_\_ No \_\_\_\_\_
18. Have you ever been judicially declared incompetent in any state, territory, or country, not previously reported in writing to this Board? Yes \_\_\_\_\_ No \_\_\_\_\_

**If any answer to any question #13 through 18 is yes, please submit a letter of description and certified copies of charges, judgment and sentencing, or certified copies of charges/complaint, findings of fact, and orders of the Board.**



Photograph must meet the following guidelines: size 2" x 2" with minimum 1" full face view without glasses; neutral background; light-colored clothing; **signed and dated on the front.**  
**Do not sign across the face.**

**AFFIDAVIT**

(Sign full name- No initials- DO NOT PRINT- If no middle name, indicate "NMN".

**I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application, may be cause for denial or loss of licensure.**

Signature of Applicant: \_\_\_\_\_

**I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this \_\_\_\_\_ date of \_\_\_\_\_, \_\_\_\_\_.**

Notary Public Signature: \_\_\_\_\_

My Commission Expires \_\_\_\_\_

(SEAL)

**OKLAHOMA BOARD OF NURSING**  
 2915 North Classen Blvd., Suite 524  
 Oklahoma City, Oklahoma 73106  
 (405) 962-1800

**OKLAHOMA INTERSTATE VERIFICATION FORM**  
**TO BE COMPLETED BY APPLICANT AND MAILED TO ORIGINAL STATE OF LICENSURE:**

Name: \_\_\_\_\_  
                     First                    Middle                    Maiden                    Married

Mailing Address \_\_\_\_\_  
                             Street Address/Box Number                            City                            State/Zip Code

Social Security Number: \_\_\_\_\_ RN \_\_\_\_\_ LPN \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the \_\_\_\_\_ Board of Nursing  
                     (signature of licensee)  (State/Country of original licensure)  
 to complete the verification form below. My records are under the name of \_\_\_\_\_  
 and license/certificate number \_\_\_\_\_.

\*\*\*\*\*

**TO BE COMPLETED BY THE LICENSING AGENCY IN THE STATE/COUNTRY OF ORIGINAL LICENSURE ONLY:**

This is to certify that the above name was issued certificate/license number \_\_\_\_\_

To practice: Registered Nursing \_\_\_\_\_ Date of issuance: \_\_\_\_\_  
                     Practical Nursing \_\_\_\_\_  
 Licensed by: Examination \_\_\_\_\_ Current licensure status: Active \_\_\_\_\_  
                     Endorsement \_\_\_\_\_ Inactive \_\_\_\_\_  
                     Waiver \_\_\_\_\_ Lapsed \_\_\_\_\_  
 Date license expires \_\_\_\_\_ Other \_\_\_\_\_

Has this license ever been revoked, suspended, surrendered, restricted, placed on probation, reprimanded, otherwise disciplined, or currently under investigation? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, please provide information.

**SBTE/NCLEX RESULTS**

	Med.	Psy.	Obs.	Surg.	Nsg. Ch.	NCLEX	SBTPE/NCLEX
Score	_____	_____	_____	_____	_____	_____	_____
Series	_____	_____	_____	_____	_____	_____	_____
Date of Exam	_____	_____	_____	_____	_____	_____	_____

Name and location of nursing program: \_\_\_\_\_  
 Type of Program (Check one) \_\_\_\_\_ PN \_\_\_\_\_ ADN \_\_\_\_\_ Diploma \_\_\_\_\_ BSN \_\_\_\_\_ Other \_\_\_\_\_  
 Was school state-approved? Yes \_\_\_\_\_ No \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

All information above is true and accurate to the best of my knowledge:  
 Signature \_\_\_\_\_ State \_\_\_\_\_  
 Title \_\_\_\_\_ Date \_\_\_\_\_

(BOARD SEAL)

**OKLAHOMA BOARD OF NURSING**  
2915 N. Classen Boulevard, Suite 524  
Oklahoma City, Oklahoma 73106  
Telephone: (405) 962-1800

DATE: \_\_\_\_\_

Type of Application: ENDORSEMENT

NAME OF NURSE: \_\_\_\_\_

**EMPLOYMENT VERIFICATION FORM**

Please authorize your immediate nursing supervisor or the director of nursing to complete this form and return it directly to the Board office by mail as soon as possible. After this information has been received in the Board office, your application will again be reviewed. Please note that the applicant may not complete any part of this form.

1. Name of Employer: \_\_\_\_\_

2. Address of Employer: \_\_\_\_\_

3. Title of Position(s) Held by Employee:

Position Title	Date Hired	Last Date in Position

4. Last Date Worked in a Licensed Position: \_\_\_\_\_

5. Current Employment Status (i.e.: currently working, suspended, on leave, terminated, etc): \_\_\_\_\_

6. Date Employee's License Card Last Viewed or Licensure Status Verified Online: \_\_\_\_\_

7. **Attach job description for all position(s) held.**

I certify that this nurse has worked 520 hours or more in a position requiring a nursing license in the past two years immediately prior to the date of completion of this form. (Check one)

Yes  
 No (If no, please indicate the number of hours worked: \_\_\_\_\_ Hours)

**The Oklahoma Nursing Practice Act (Oklahoma Statutes 59 O.S. § 567.1 et seq.) requires that any person who represents himself/herself as a registered nurse or licensed practical nurse in this state must have a current Oklahoma license to practice registered nursing or licensed practical nursing. Continued employment in nursing (including orientation to a position that requires a nursing license) without a valid nursing license is considered in violation of the provisions of the Oklahoma Nursing Practice Act and may subject the person to disciplinary action.**

I have read the above statement. I certify that the statements contained herein are true and correct.

Signed: \_\_\_\_\_  
Title: \_\_\_\_\_  
Name of Institution: \_\_\_\_\_  
Address of Institution: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Date this information was completed: \_\_\_\_\_

# CRIMINAL HISTORY INFORMATION REQUEST

Oklahoma State Bureau of Investigation  
Criminal History Reporting Unit  
6600 North Harvey Oklahoma City, OK 73116  
(405) 848-6724

Date \_\_\_\_\_

PURSUANT TO PROVISIONS OF TITLE 51, OKLAHOMA STATUTES 1981, SECTION 24A.1 et seq. AND PROCEDURES OUTLINED BY THE OKLAHOMA STATE BUREAU OF INVESTIGATION, I REQUEST A CRIMINAL HISTORY INFORMATION CHECK OF YOUR FILES ON THE FOLLOWING SUBJECT (S). THE PROCESSING FEE OF FIFTEEN DOLLARS (\$15.00) PER SUBJECT FOR A NAME SEARCH OR NINETEEN DOLLARS (\$19.00) PER SUBJECT FOR AN IN-STATE FINGERPRINT SEARCH IS HEREBY TENDERED

Form of Payment:  Cash  Business Check  Money Order  Cashier's Check  
 Visa  MasterCard  Discover Account Number \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_ Expiration Date \_\_\_\_\_  
(Requests with no signature will be returned unprocessed.)

NAME OF INDIVIDUAL, BUSINESS,  
OR AGENCY MAKING REQUEST \_\_\_\_\_  
If paying with cash, money order, cashier's check or credit card, this information will be  
YOUR NAME AND ADDRESS.

INDIVIDUAL, BUSINESS,  
OR AGENCY ADDRESS \_\_\_\_\_  
Street Address or Post Office Box

PHONE  
NUMBER: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ City State ZIP

Purpose of Request \_\_\_\_\_

**(PLEASE CHECK, ONLY IF APPLICABLE)**  
This request is being made in compliance with the provisions of the Oklahoma Child Care Facilities Licensing act, 10 O.S. 1991, Sections 401 through 410; a search of the Oklahoma Department of Corrections Sex Offenders Registration List, 57 O.S. 1991, Section 581 et seq., is required: \_\_\_\_\_. The sex offender search must be requested at the time the original criminal history record check is submitted; amended replies to include this information will not be furnished free of charge at a later date.

FOR OSBI USE ONLY-DO NOT WRITE IN THIS SPACE.

\_\_\_\_\_  
Signature of Requestor

**SUBJECT TO BE SEARCHED:**  
(All request forms must be **typed** or the information **legibly printed in ink** by the requestor; forms completed in **pencil are unacceptable**. Handwritten requests which are not easily read will be returned unprocessed.)

NAME \_\_\_\_\_  
(Last First Middle)

Alias Names \_\_\_\_\_  
(include maiden name, all married names, and any other names used)

RACE \_\_\_\_\_ SEX \_\_\_\_\_

DATE OF BIRTH  
OR AGE (mandatory) \_\_\_\_\_  
(If an age is provided, it must be specific; an age range is not acceptable and will be returned unprocessed. Additionally, customers who submit common names with an age may be required to provide full date of birth before the request can be processed. See Title 51 section 24A.5 (2) of the Oklahoma Open Records Act.)

SOCIAL SECURITY NUMBER \_\_\_\_\_

FOR OSBI USE ONLY - DO NOT WRITE IN THIS SPACE

All criminal history record information provided in compliance with 51 O.S. 1981, Section 24A.1 et seq., is based upon fingerprints taken by the contributing law enforcement or criminal justice agency at the time of arrest and/or incarceration.  
(Form #CHRD01)



## Oklahoma Third-Party Authorization

I \_\_\_\_\_, the undersigned, do hereby authorize

\_\_\_\_\_ International Department \_\_\_\_\_, whose address is

All About Staffing, Inc  
1000 Sawgrass Corp. Pkwy., 6<sup>th</sup> Fl  
Sunrise, FL 33323

his/her agents, employees, to act for me and in my name with respect to my application for licensure with the Oklahoma Board of Nursing, with the exception of withdrawing my application or requesting a refund.

Date \_\_\_\_\_ Signature \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

This instrument was acknowledged before me on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ by

\_\_\_\_\_  
Seal  
Notary Public