

# Application Checklist

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Please use the following checklist to help ensure your application is complete.

## **Completed Application with Signature**

An incomplete application will delay final approval of that application. All documents become a permanent part of your file and cannot be returned. Applications are reviewed in date order received.

Every question on the application must be answered. Be sure to answer all questions honestly. The Board of Nursing may deny your application if you provide false information on your application.

## **Proof of Active Certification**

Your out-of-state certificate must be Clear/Active and in good standing.

## **Completed Confidential and Exempt from Public Records Disclosure Form**

Form enclosed

## **Livescan**

All applications received must include electronically submitted fingerprints through a Livescan provider. The Department of Health accepts electronic fingerprinting offered by Livescan providers that are approved by the Florida Department of Law Enforcement.

For a list of approved Livescan vendors *and* Frequently Asked Questions about Livescan please visit our website at: <http://www.flhealthsource.gov/background-screening/>

Our current ORI number is EDOH4400Z.

<http://floridasnursing.gov/forms/electronic-fingerprinting-form-cna-by-exam.pdf>

## **Applications and other additional documents must be mailed to:**

Department of Health  
Certified Nursing Assistant Registry  
4052 Bald Cypress Way Bin# C-02  
Tallahassee, FL 32399-3252

# Important Information

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## **Application Updates**

The Board office must be notified in writing of anything which changes or affects a response given in your application. Failure to do so could result in the delay of application processing or denial of your application. Examples: change of name, address, telephone number, arrests or convictions, licensure status or disciplinary action in another state, or an incorrect answer to a question.

## **Withdrawal of Application**

If you decide to withdraw your application, you must make the request in writing. The request must be received prior to the Board considering licensure.

## **Criminal History**

Any applicant who has ever been found guilty of, or pled guilty or no contest to/nolo contendere, any charge other than a minor traffic offense must list each offense on the application. Failure to disclose criminal history may result in denial of your application. Each application is reviewed on its own merits. Staff cannot make predeterminations in advance as laws and rules do change over time. Violent crimes and repeat offenders are required to be presented to the Board of Nursing for review.

## **Applicants with criminal convictions may be required to submit the following documents:**

**Final Dispositions/Sanctions** –Final disposition records for offenses can be obtained at the clerk of the court in the arresting jurisdiction. If the records are not available, you must have a letter on court letterhead sent from the Clerk of the Court attesting to their unavailability.

**Completion of Probation/Parole** –Probation records for offenses can be obtained at the clerk of the court in the arresting jurisdiction. If the records are not available, you must have a letter on court letterhead sent from the Clerk of the Court attesting to their unavailability.

**Self-Explanation** –Applicants who have listed offenses on the application must submit a letter in your own words describing the circumstances of the offense.

**Letters of Recommendation** –Applicants who have listed offenses on the application must submit 3-5 letters of recommendation from people you have worked for or with.

## **Disciplinary History**

Any applicant who has ever been denied, had disciplinary action, or surrendered a license to practice in any healthcare profession, in any state, jurisdiction, or country must provide a self-explanation of all occurrences of denial, disciplinary action or surrendering of a license. The State Board(s) of Nursing involved must also submit copies of the **administrative complaint** and **final order** directly to the Florida Board. Applicants are responsible to ensure that the proper documentation is sent to the Florida Board. Any action taken against your license by a state licensing board must be reported on this application.

## **Healthcare Fraud**

**IMPORTANT NOTICE:** Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure; certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. For more information, please visit our website at:

<http://floridasnursing.gov/licensing/certified-nursing-assistant-endorsement/>.

Florida Board of Nursing  
PO Box 6330  
Tallahassee, FL 32314  
Phone: (850) 245-4125  
Fax: (850) 617-6460

# Certified Nursing Assistant Licensure by Endorsement Application

Website: [www.floridasnursing.gov](http://www.floridasnursing.gov)  
Email: [mqa.cna@flhealth.gov](mailto:mqa.cna@flhealth.gov)  
Please complete this application in its  
entirety prior to printing.

## 1. PERSONAL INFORMATION

<b>Name:</b> _____			<b>Date of Birth:</b> _____	
Last/Surname	First	Middle	MM/DD/YYYY	
<b>Mailing Address: (Give the address where mail and your license should be sent)</b>				
Street/P.O. Box			Apt. No.	City
State	Zip	Country	Home/Cell Telephone (Input with dashes)	
<b>Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)</b>				
Street		Apt./Suite No.	City	
State	Zip	Country	Work/Cell Telephone (Input with dashes)	
<b>EQUAL OPPORTUNITY DATA:</b> We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.				
SEX:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	RACE:	
			<input type="checkbox"/> White	
			<input type="checkbox"/> Black or African American	
			<input type="checkbox"/> Hispanic	
			<input type="checkbox"/> American Indian or Alaska Native	
			<input type="checkbox"/> Asian	
			<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
			<input type="checkbox"/> Two or More Races	

NAME \_\_\_\_\_

**Email Notification:** If you want to be notified of the status of your application by email please check the "Yes" box and write your email address on the line provided below. If you choose this form of notification you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the Board office at: [mqa.cna@fihealth.gov](mailto:mqa.cna@fihealth.gov)

I want to be notified by email  Yes  No

Email Address: \_\_\_\_\_

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

**2. APPLICANT BACKGROUND Attach additional sheets, if necessary**

A. List any other name(s) by which you have been known in the past. \_\_\_\_\_

B. What name(s) did you use when you received your education? \_\_\_\_\_

C. What name did you use when you were first licensed? \_\_\_\_\_

D. Have you ever applied for licensure by examination in Florida, as a CNA? Date \_\_\_\_\_

Yes  No

E. Have you ever applied for licensure by endorsement in Florida, as a CNA? Date \_\_\_\_\_

Yes  No

F. Have you ever been licensed in Florida as a CNA? Date \_\_\_\_\_

Yes  No

G.\* Have you ever been denied or is there now any proceeding to deny your application for any health care license to practice in Florida or any other state, jurisdiction or country?

Yes  No

\*If you answer "Yes" to question G in this section, you must submit a self explanation as to why you are answering "Yes" to this question.

NAME \_\_\_\_\_

H. List all CNA licenses (active, inactive or lapsed)

<u>State/Country</u>	<u>License No.</u>	<u>License Type</u>	<u>Date of Licensure</u>	<u>Status of License and Expiry Date</u>

The Florida Board of Nursing requires verification of licensure from from a state where you have a current active license.

3. **CRIMINAL HISTORY** Answers to commonly asked questions can be found on our website at: <http://www.floridasnursing.gov/help-center/#faqs>

- A.  Yes  No Have you **EVER** been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld**.  
**Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**
- B.  Yes  No Have you **EVER** had any records sealed pursuant to section 943.059, F.S., or other states applicable statute?
- C.  Yes  No Have you **EVER** been adjudicated delinquent?

Failure to disclose information in this section may result in a denial of your application.

If you answered "Yes" to any of the questions above you are required to send the following items:

- Self Explanation** describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.
- Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- Completion of Sentence Documents.** You may obtain documents from the Department of Corrections. The report must include the start date, end date, and state that the conditions have been met.
- Three (3) current (written within the last year) **Letters of Recommendation.**

NAME \_\_\_\_\_

**4. Electronic Fingerprinting: (Required for ALL applicants)**

All applicants, including out-of-state and out-of-country applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan device providers that are approved by the Florida Department of Law Enforcement. For a list of approved Livescan vendors, please visit our website at : <http://www.flhealthsource.gov/background-screening/>

Typically background results submitted by Livescan are received by the Board within 24-72 hours of being processed. The Board of Nursing's ORI number is: **EDO4400Z**. **The Board cannot accept hard fingerprint cards or results**. All results must be submitted electronically by the Livescan service provider.

Livescan screenings done by a Florida Police or Sheriff's Department require that you login to the FDLE Civil Applicant Payment System (CAPS) at <https://caps.fdle.state.fl.us> and pay a fee before results will be released to our office.

Applicants who reside in an area where no Livescan service providers are available or because of state laws prohibiting transmission of fingerprints electronically across state lines should contact a Florida Livescan service provider who has the capability to convert a traditional card (hard card) into an electronic fingerprint card.

Because the Florida Department of Health retains fingerprints on any applicant who is required to undergo a criminal history screening as of January 1, 2013, those prints are retained in the Care Provider Clearinghouse. This Clearinghouse allows for the sharing of criminal history information among specified agencies.

One of the requirements for your Livescan to be retained in the Clearinghouse is a photograph taken by the Livescan service provider at time of fingerprinting. If your Livescan is completed without a photograph, you may have to undergo additional fingerprinting in the future.

**Applicants needing hard fingerprint cards can request them via email at:** [Mqa.BackgroundScreen@flhealth.gov](mailto:Mqa.BackgroundScreen@flhealth.gov)

- Please include your current mailing address in your request for fingerprint cards.
- **The Board cannot accept hard fingerprint cards or results.**

For Frequently Asked Questions about Livescan and for a list of providers who offer hard card conversion see our website at:  
<http://www.flhealthsource.gov/background-screening/>

**LIVESCAN PRIVACY STATEMENT**

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation. (Found in the forms following this application). The Board will not receive your Livescan results if you do not affirm the above statement by checking this box.

NAME \_\_\_\_\_

**5. DISCIPLINARY HISTORY**

- A.  Yes  No Have you ever had disciplinary action taken against your license to practice any health care related profession by the licensing authority in Florida or in any other state, jurisdiction or country?
- B.  Yes  No Have you ever surrendered a license to practice any health care related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?
- C.  Yes  No Do you have disciplinary action pending against any license?

**Failure to disclose information in this section may result in a denial of your application.**

**If you answered "Yes" to any of the questions in this section, you are required to send the following items:**

- Self Explanation**, describing in detail the circumstances surrounding the disciplinary action.
- A copy of the **Administrative Complaint and Final Order**.
- Three (3) current (written within the last year) **Letters of Recommendation**.

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**6. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS**

**IMPORTANT NOTICE:** Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

1.  Yes  No Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

**If you responded "No" to the question above, skip to question 2.**

- a.  Yes  No If "Yes" to 1, were you arrested or charged for the felony or felonies after July 1, 2009?
- b.  Yes  No If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?
- c.  Yes  No If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).

NAME \_\_\_\_\_

d.  Yes  No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

e.  Yes  No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "Yes", please provide supporting documentation).

2.  Yes  No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

**If you responded "No" to the question above, skip to question 3.**

a.  Yes  No If "Yes" to 2, were you arrested or charged for the felony or felonies after July 1, 2009?

b.  Yes  No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3.  Yes  No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

**If you responded "No" to the question above, skip to question 4.**

Yes  No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4.  Yes  No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?

**If you responded "No" to the question above, skip to question 5.**

a.  Yes  No Have you been in good standing with a state Medicaid program for the most recent five years?

b.  Yes  No Did the termination occur at least 20 years before to the date of this application?

5.  Yes  No Are you currently listed on the United States Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals and Entities?



7.

## Confidential and Exempt from Public Records Disclosure

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Pursuant to Sec. 466 [42 U.S.C. 666](a), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security Numbers as part of the general licensing provisions. This information is exempt from public records disclosure.

**Last Name:**

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**First Name:**

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**Middle Name:**

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**Social Security Number:**

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(Input with dashes)

**Social Security Information** - \* Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act, 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at [www.ssa.gov](http://www.ssa.gov) or by calling 1-800-772-1213.

Board of Nursing  
4052 Bald Cypress Way, Bin # C02  
Tallahassee, Florida 32399-3252  
Phone: (850) 245-4125 Fax: (850) 617-6460  
Website: [www.floridasnursing.gov](http://www.floridasnursing.gov)

NAME \_\_\_\_\_

**8. HEALTH HISTORY (Supporting documentation should be sent directly to the board office.)**

- A.  Yes  No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?
- B.  Yes  No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?
- C.  Yes  No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice nursing within the past five years?
- D.  Yes  No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?
- E.  Yes  No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice nursing within the past five years?

**If you answered "Yes" to any of the questions in this section, you are required to send the following items:**

- Self Explanation**, explaining the medical condition(s) or occurrence(s) and current status.
- Letter(s) from a Licensed Professional** summarizing diagnosis, treatment and prognosis; or any other official documentation as it relates to any "Yes" answer. Documentation must be current within the last year.

NAME \_\_\_\_\_

9. ADDITIONAL INFORMATION

Availability for Disaster:

Yes

No

Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

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10. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the State of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.082, 775.083 and 775.084, Florida Statutes.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Registered Nurse or Licensed Practical Nurse in the State of Florida.

I further state that I have read and understand Chapter 464, Florida Statutes, and Rule Chapter 64B9, Florida Administrative Code as they pertain to the practice of nursing (Note: Ch 464 and Rule Chapter 64B9 may be obtained via the internet at [www.floridasnursing.gov](http://www.floridasnursing.gov)).

Florida Law requires you to immediately inform the Board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I will comply with all requirements for licensure renewal, including in-service training hours.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
This field cannot be typed. You must print out the application and sign it. MM/DD/YYYY

**All applications filed with the department are valid for one (1) year from the date of receipt or until the examination scores are received by the department, which ever comes first.**

# Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at:  
<http://www.flhealthsource.gov/background-screening/>
- Livescan screenings done by a Florida Police or Sheriff's Department require that you login to the FDLE Civil Applicant Payment System (CAPS) at <https://caps.fdle.state.fl.us> and pay a fee before results will be released to our office.
- Out of State/Country Livescan directions are included in the electronic fingerprinting section of this application.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**;
- The ORI number for the Board of Nursing is: **EDOH4400Z**.
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: \_\_\_\_\_

Aliases: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
(MM/DD/YYYY)

Citizenship: \_\_\_\_\_ Race: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
(W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
(M=Male; F=Female)

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Transaction Control Number (TCN#): \_\_\_\_\_  
(This number will be provided to you by the Live Scan Vendor.)

*You will need to keep this form for your records. Do not send this form to the Board Office.*

## FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

### NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

**Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.**

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

**The FBI's Privacy Statement follows on a separate page and contains additional information.**

### PRIVACY STATEMENT

**Authority:** The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

**Social Security Account Number (SSAN).** Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

**Principal Purpose:** Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI( may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

**Routine Uses:** The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice,FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

**Additional Information:** The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Complete verifications must be mailed directly from the verifying agency to:

Florida Board of Nursing  
4052 Bald Cypress Way  
Bin # C02  
Tallahassee, FL 32399-3252

## Florida Board of Nursing License Verification Request

- \* Verification must be sent directly to our office by the verifying agency. **Copies of licenses and website screen shots do not meet the requirement for verification of licensure.**
- \* You are responsible for any fees incurred for verification of your licensure.

### **PART I: TO BE COMPLETED BY APPLICANT (Send to your current state(s) of licensure. Make copies if necessary.)**

Applicant Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Name original license was issued under: \_\_\_\_\_

License Number: \_\_\_\_\_ State of: \_\_\_\_\_

I hereby authorize release of any information regarding my licensure status to the Florida Board of Nursing.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### **PART II: TO BE COMPLETED BY YOUR STATE BOARD OF NURSING**

#### **All verifications must be in English and include the following criteria:**

- \* Typed on an official state form or letterhead
- \* Include an official Board seal
- \* Signature and title of state Board official

#### **The following information must be included in all verifications:**

- \* Licensee name
- \* License number
- \* State or jurisdiction of licensure
- \* Licensure status
- \* Is license in good standing?
- \* Level of licensure (CNA)
- \* Dates of issuance/expiration
- \* Licensure method (state exam, national exam, endorsement, reciprocity)
- \* Has this license ever been encumbered (denied, revoked, suspended surrendered, limited, placed on probation)?
- \* If this license has ever been encumbered please forward all orders to the Florida Board of Nursing with this form.