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# Nurse Practitioner Application Packet

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The University of the State of New York  
THE STATE EDUCATION DEPARTMENT

Office of the Professions  
Division of Professional Licensing Services  
89 Washington Avenue  
Albany, NY 12234-1000

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**(Rev. 3/09)**

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FORM 1	-	Application for a Certificate
FORM 2	-	Certification of Professional Education
FORM 2B	-	Verification of Instruction in New York State and Federal Laws Related to Prescriptions and Record Keeping
FORM 2C	-	Verification of Pharmacotherapeutics Course
FORM 3	-	Verification of National Nurse Practitioner Examination
FORM 4	-	Verification of Experience
FORM 4NP	-	Verification of Collaborative Agreement and Practice Protocol

## Additional Forms

FORM AD/NAME	-	Address/Name Change Form
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### **FOR FUTURE REFERENCE**

**IN THE EVENT OF AN EMERGENCY** that impacts the licensed professions, the Office of the Professions will provide important information, specific to the situation, through our **Web site** ([www.op.nysed.gov](http://www.op.nysed.gov)), our **automated phone system** (518-474-3817), and/or our **regional offices**. This information will include emergency provisions for professional practice as well as updates on scheduled events and services (licensing examinations, professional discipline proceedings, examination reviews, etc.).

## Ways to reach us...



### ⇒ General Customer Service

The Office of the Professions has an automated customer service system that allows callers to **verify licenses, request information, and hear automated messages 24 hours a day.** The number is 518-474-3817, TDD/TTY 518-473-1426. Staff are available from 8:30 a.m. to 4:45 p.m., Eastern Time, Monday through Friday. You may also fax a message to 518-474-1449 or e-mail us at [op4info@mail.nysed.gov](mailto:op4info@mail.nysed.gov).

### ⇒ On The World Wide Web

Information about the Office of the Professions and the 47 licensed professions, including information on all licensees, is available on our home page at:

**[www.op.nysed.gov](http://www.op.nysed.gov)**

### ⇒ Certificate Application Status

Find out the **status of your certificate application** by checking our Web site where your name is added immediately when a certificate is issued, or contact:

New York State Education Department, Office of the Professions, Division of Professional Licensing Services  
**Nurse Practitioner Unit**, 89 Washington Avenue, Albany, NY 12234-1000  
PHONE: 518-474-3817 ext. 270, FAX: 518-402-5354, E-MAIL: [opunit3@mail.nysed.gov](mailto:opunit3@mail.nysed.gov)  
Please include your name, social security number, date of birth, and the name of the profession.

### ⇒ Verification of Education Credentials From Foreign or Non-Approved Programs

If you have questions about documentation required to verify education completed outside the U.S. or in non-approved programs, contact:

New York State Education Department, Office of the Professions, **Bureau of Comparative Education**  
89 Washington Avenue, Albany, New York 12234-1000  
PHONE: 518-474-3817 ext. 300, FAX: 518-486-2966, E-MAIL: [comped@mail.nysed.gov](mailto:comped@mail.nysed.gov)

### ⇒ Practice Issues

For answers to questions concerning practice issues, contact:

NYS Education Department, Office of the Professions, **State Board for Nursing**  
89 Washington Avenue, Albany, NY 12234-1000  
PHONE: 518-474-3817 ext. 120, FAX: 518-474-3706, E-MAIL: [nursebd@mail.nysed.gov](mailto:nursebd@mail.nysed.gov)

# APPLYING FOR A CERTIFICATE AS A NURSE PRACTITIONER

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## GENERAL REQUIREMENTS

Use of the title "Nurse Practitioner" within New York requires a certificate issued by the New York State Education Department.

**To receive a certificate to practice as a nurse practitioner in New York State you must:**

- have a currently registered New York State license as a Registered Professional Nurse (RN); and
- meet education requirements.

A nurse practitioner is authorized to practice in a **specific specialty area**. You may be authorized in more than one specialty. Current specialty areas are: Acute Care, Adult Health, College Health, Community Health, Family Health, Gerontology, Holistic Care, Neonatology, Obstetrics/Gynecology, Oncology, Pediatrics, Palliative Care, Perinatology, Psychiatry, School Health, Women's Health.

You must file an Application for a Certificate (Form 1) for each specialty area you want to be authorized in and all other forms indicated to demonstrate that you have satisfied the education requirements specific to that specialty area, along with the appropriate fee, to the Office of the Professions at the address specified on each form. **It is your responsibility to follow up with anyone you have asked to send us material.** Once authorized, you must maintain the registration of your RN license and your NP certificate in order to practice as a nurse practitioner.

The specific requirements to obtain a certificate are contained in Title 8, Article 139, Section 6910 of New York's Education Law and Part 64 of the Commissioner's Regulations. For additional information regarding legal requirements for licensed/certified professionals, see the section on "Professional Conduct."

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## FEES (fees listed are those in effect at the time this application was printed)

The fee for a certificate in each nurse practitioner specialty area is \$85. (\$50 certificate application fee plus a \$35 fee for initial registration.)

Fees are subject to change. The fee due is the one in law when your application is received (unless fees are increased retroactively). You will be billed for the difference if fees have been increased.

- Do not send cash.
- Make your personal check or money order payable to the New York State Education Department.  
**Your cancelled check is your receipt.**
- Mail your application and fee to: **NYS Education Department, Office of the Professions at the address at the end of the Application for a Certificate (Form 1).**

**PLEASE NOTE:** Payment submitted from outside the United States should be made by check or draft on a United States bank and in United States currency; payments submitted in any other form will not be accepted and will be returned.

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## PARTIAL REFUNDS

Individuals who withdraw their application for a certificate any time prior to a determination may be entitled to a partial refund.

- For the procedure to withdraw your application, contact the Nurse Practitioner Unit by e-mailing opunit3@mail.nysed.gov or by calling 518-474-3817 ext. 270 or by faxing 518-402-5354.
- The State Education Department is not responsible for any fees paid to an outside testing or credentials verification agency.

If you withdraw your application, obtain a refund, and then decide to seek a New York State certificate at a later date, you will be considered a new applicant, and you will be required to pay the application fee and meet the requirements for a certificate that are in place at the time you reapply.

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## ADDRESS OR NAME CHANGES

If your mailing address or name changes, you must contact the Department to update your records and provide the following identifying information: your full name, social security number, profession and date of birth. Failure to provide the Department with your change of address or name will delay processing your application.

**For address changes** you may phone, fax or e-mail:

Phone: 518-474-3817 ext. 270  
TDD/TTY 518-473-1426

Fax: 518-402-5354

E-mail: [opunit3@mail.nysed.gov](mailto:opunit3@mail.nysed.gov)

**For name changes** a fax or e-mail is not acceptable. You must provide written notification of any name change with an original notarized signature in your new name to:

NYS Education Department, Office of the Professions  
Division of Professional Licensing Services  
Nurse Practitioner Unit  
89 Washington Avenue  
Albany, NY 12234-1000

**NOTE: Once you have obtained a certificate, Education Law requires that you notify the Department of any change in your mailing address or name within 30 days of that change. Failure to do so may be considered professional misconduct. It may also delay renewal and result in late fees to renew.** You may use the Form AD/NAME located in the back of this packet or print a copy from our Web site at [www.op.nysed.gov/anchange.pdf](http://www.op.nysed.gov/anchange.pdf) to notify the Department of a change in your address or name.

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## PROFESSIONAL CONDUCT

All licensed/certified practitioners must adhere to rules of professional conduct. The Education Law includes definitions of professional misconduct, and the Board of Regents has adopted Rules defining unprofessional conduct for all professions. Every licensee is also governed by a set of Laws, Rules, and Regulations for the practice of the profession.

Title 8 of the NYS Education Law is available on our Web site at [www.op.nysed.gov/title8.htm](http://www.op.nysed.gov/title8.htm)

Part 29 of the Rules of the Board of Regents is available on our Web site at [www.op.nysed.gov/part29.htm](http://www.op.nysed.gov/part29.htm)

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## EDUCATION REQUIREMENTS

To satisfy the education requirements for a certificate as a nurse practitioner, you must present evidence of satisfying the requirements of A or B or C below. Additionally, you must meet the requirements for D below.

**A. Completion of a nurse practitioner education program registered by the New York State Education Department as qualifying for a certificate**, or a program determined by the Department to be equivalent to a registered program, which is designed and conducted to prepare graduates to practice as nurse practitioners.

**B. Certification as a nurse practitioner by one of the following national certifying organizations:**

American Academy of Nurse Practitioners  
P.O. Box 12846  
Austin, TX 78711  
Phone: 512-442-4262  
Web: [www.aanp.org](http://www.aanp.org)

American Holostic Nurses Certification Corporation  
811 Linden Loop  
Cedar Park, Tx. 78610  
Phone: 512-528-9210  
E-mail: [AHNCC@Flash.net](mailto:AHNCC@Flash.net)

American Nurses Credentialing Center  
Attn: Verification Specialist  
P.O. Box 791321  
Baltimore, MD 21279-1321  
Web: <http://nursingworld.org/ancc/>

National Board for Certification of Hospice and Palliative Nurses  
One Penn Center West  
Pittsburgh, Pa 15276-0100  
Phone: 412-787-1057  
E-mail: [nbchpn@hpna.org](mailto:nbchpn@hpna.org)

National Certification Corporation  
(Formerly NAACOG)  
P.O. Box 11082  
Chicago, IL 60611-0082  
Phone: 312-951-0207  
Web: [www.nccnet.org](http://www.nccnet.org)

(Certification for women's health, neonatal and gynecologic/reproductive nurse practitioners.)

Oncology Nursing Certification Corporation  
125 Enterprise Drive  
Pittsburgh, PA 15275  
Phone: 877-769-6622  
Web: [www.oncc.org](http://www.oncc.org)

Pediatric Nursing Certification Board  
800 South Frederick Avenue, Suite 204  
Gaithersburg, MD 20877-4152  
Phone: 301-330-2921 or 888-641-2767  
Web: [www.pncb.org](http://www.pncb.org)

**C. Satisfaction of alternative requirements for a certificate for graduates of nurse practitioner programs prior to April 1, 1989, as follows:**

- completion of at least a four-week long (full-time) nurse practitioner program prior to April 1, 1989;

**and either**

- two years of experience prior to April 1, 1989, of which one year must be after April 1, 1986, in the provision of primary health care services in a health care facility licensed pursuant to Article 28 of the Public Health Law or in a school health demonstration project;

**or**

- completion of a supplemental educational program culminating in the successful completion of a comprehensive examination or clinical evaluation.

**AND**

**D. Satisfaction of the pharmacotherapeutic requirement** (for all applicants, regardless of whether A, B, or C above was completed). You must document:

- completion of not less than three semester hours, or the equivalent, in pharmacotherapeutics to include instruction in drug management of clients in the nurse practitioner specialty area and instruction in New York State and Federal laws and regulations relating to prescriptions and record keeping;

**or**

- completion of an educational program or a combination of courses which is the substantial equivalent in content and scope to the pharmacotherapeutics course listed above;

**or**

- satisfactory completion of an examination in pharmacotherapeutics acceptable to the Department;

**or**

- satisfactory completion of a nationally recognized examination acceptable for licensure in New York State as a physician assistant or for certification as a nurse midwife.

**Please Note:** If you have completed a program other than one that is registered by New York State as qualifying for a nurse practitioner certificate and/or your pharmacotherapeutics course did not include instruction in New York State and Federal laws and regulations related to prescriptions and record keeping, you may contact the following professional associations for required instruction:

The Nurse Practitioner Association of New York State  
12 Corporate Drive  
Clifton Park, New York 12065  
Phone: 518-348-0719  
Web: [www.thenpa.org](http://www.thenpa.org)

The New York State Nurses Association  
11 Cornell Road  
Latham, NY 12110-1499  
Phone: 518-782-9400 ext. 278  
Web: [www.nysna.org](http://www.nysna.org)

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## **PRESCRIPTION FORMS**

If you satisfy all requirements for a certificate as a nurse practitioner, you will be authorized to issue prescriptions pursuant to Section 6902 (3) (b) of the Education Law.

**New York State Prescription Forms** may be obtained from:

New York State Department of Health  
Bureau of Narcotic Enforcement  
433 River Street, Suite 303  
Troy, NY 12180  
Phone: 866-811-7957 or 518-402-0708

### **National Provider Identifier (NPI)**

All health care providers - including those serving Medicare beneficiaries - are now required to apply for a new National Provider Identifier (NPI) that will be used in all electronic health care transactions. The NPI will replace all other provider identifiers currently being used. The National Provider Identifier initiative was mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and requires that NPIs be used by health plans, health care clearinghouses, and health care providers that process

claims, handle claim status inquiries/responses and eligibility inquiries/responses, as well as other transactions. Nurse practitioners can apply for an NPI by going to <http://nppes.cms.hhs.gov>. Applications can be submitted online or via regular mail.

### **Federal Drug Enforcement Administration Number (DEA)**

A Federal Drug Enforcement Administration (DEA) Number is required to prescribe and dispense narcotic and controlled substances. A DEA number may be obtained from:

United States Department of Justice  
Drug Enforcement Administration  
99 10th Avenue  
New York, NY 10011  
Phone: 877-883-5789, 800-882-9539 or 212-337-1593  
Fax: 212-337-2867 or 2895  
Web: [www.deadiversion.usdoj.gov](http://www.deadiversion.usdoj.gov)

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## **COLLABORATIVE AGREEMENTS AND PROTOCOL TEXT**

### **Collaborative Agreement**

You are required to establish a collaborative agreement with *one* physician prior to beginning practice and maintain that agreement in the practice setting(s) where it will be available for inspection by the State Education Department (SED). New practitioners are also required to submit Form 4NP-Verification of Collaborative Agreement and Practice Protocol only once to the SED's Office of the Professions no later than 90 days after beginning professional practice.

The collaborative agreement shall include provisions for referral and consultation, coverage for absences of either the nurse practitioner or the collaborating physician, resolution of disagreements between the nurse practitioner and the collaborating physician regarding matters of diagnosis and treatment, the review of a representative sample of patient records every three months by the collaborating physician, record keeping provisions and any other provisions jointly determined by the nurse practitioner and the physician to be appropriate. A sample collaborative agreement is included for your convenience.

### **Protocol Text as Practice Protocol**

You are also required to identify a protocol text, from the approved list on pages 8-10, as your official practice protocol which must reflect the specialty area of practice as identified on your State Education Department issued nurse practitioner certificate. The approved protocol texts include provisions for case management, diagnosis and treatment of pathology in the specialty area. Additional protocols or textbooks which may be appropriate to the practice and/or employment setting may be used but need not be reflected in the collaborative agreement.

Questions about collaborative agreements and practice protocols may be referred to the State Board for Nursing by e-mailing [nursebd@mail.nysed.gov](mailto:nursebd@mail.nysed.gov) or by calling 518-474-3817 ext. 120, or by faxing 518-474-3706.

## **(Sample) Collaborative Practice Agreement**

This agreement sets forth the terms of the Collaborative Practice Agreement between (nurse practitioner and specialty as listed on the State issued certificate) and (name of collaborating physician and specialty if any) at (name and address of agency or entity where practice takes place). This agreement shall take effect as of (date).

### **Introduction**

(YOUR NAME RN, NP) meets the qualifications and practice requirements as stated in Chapter 257 of the Laws of 1988 and Article 139 of the Education Law of New York State, holds a New York State license and is currently registered as a registered professional nurse in good standing, holds a certificate as a nurse practitioner pursuant to Sec. 6910 of the Education law and herein meets the requirement of maintaining a collaborative practice agreement with (NAME OF COLLABORATOR, MD/DO) a duly licensed and currently registered physician in good standing under Article 131 of the New York State Education Law.

### **I. Scope of Practice**

The practice of a registered professional nurse as a nurse practitioner may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures including prescribing medications for patients whose conditions fall within the authorized scope of the practice as identified on the college certificate. This privilege includes the prescribing of all controlled substances under a DEA number. The nurse practitioner, as a registered nurse, may also diagnose and treat human responses to actual or potential health problems through such services as case finding, health counseling, health teaching, and provision of care supportive to or restorative of life and well-being. This practice will take place at (above identified agency) or in such other facility or location as designated by (name of identified agency) or by the parties of this contract. The following exceptions to the certified scope of practice have been agreed upon by the undersigned parties: (list exception(s)).

### **II. Practice Protocols**

The protocols used in this (identify specialty as listed on State issued certificate) practice are contained in (name approved protocol text with all bibliography citations) and in (cite location of any other protocols which are germane to this particular practice).

### **III. Physician Consultation**

The parties shall be available to each other for consultation either on site or by electronic access including but not limited to telephone, facsimile and email. Each party will cover for the other in the absence of one of them or (names of third parties) who are designated by (YOUR NAME, RN, NP and NAME OF COLLABORATOR MD/DO) as appropriate for coverage in the absence of both parties. In the event that there is an unforeseen lack of coverage, patients will be referred to the appropriate emergency room.

### **IV. Record Review**

A representative sample of patient records shall be reviewed by the collaborating physician every three months to evaluate that (name of NP)'s practice is congruent with the above identified practice protocol documents and texts. Summarized results of this review will be signed by both parties and shall be maintained in the nurse practitioner's practice site for possible regulatory agency review. Consent forms for such review will be obtained from any patient whose primary physician is other than (name of collaborating physician).

**V. Resolution of Disagreements**

Disagreement between (name of nurse practitioner) and (name of collaborating physician) regarding a patient's health management that falls within the scope of practice of both parties will be resolved by a consensus agreement in accordance with current medical and nursing peer literature consultation. In case of disagreements that cannot be resolved in this manner, (name of collaborative physician's) opinion will prevail. In disagreements between the nurse practitioner and non-collaborating physicians, the collaborating physician's opinion will prevail.

**VI. Alteration of Agreement**

The collaborative practice agreement shall be reviewed at least annually and may be amended in writing in a document signed by both parties and attached to the collaborative practice agreement.

**VII. Agreement**

Having read and understood the full contents of this document, the parties hereto agree to be bound by its terms.

**Nurse Practitioner (Specialty):**

Printed Name \_\_\_\_\_ RN license # \_\_\_\_\_

Certificate # \_\_\_\_\_

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

**Collaborating Physician:**

Printed Name \_\_\_\_\_ MD license # \_\_\_\_\_

Board Certification \_\_\_\_\_

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

## APPROVED PROTOCOL TEXTS

(Please note: more recently published editions of the same text title are acceptable)

- American Academy of Pediatrics Staff. (2003). *School health, policy and practice*. Elk Grove Village, IL: American Academy of Pediatrics.
- American Academy of Pediatrics Staff. (2008). *Pediatric primary care: Tools for practice*. Elk Grove Village, IL: American Academy of Pediatrics.
- American Academy of Pediatrics. (2006). *2006 Red book: report of the committee on infectious diseases*. Elk Grove Village, IL.: American Academy of Pediatrics.
- American Psychiatric Association Staff. (2000). *Diagnostic and statistical manual of mental disorders, DSM-IV-TR: Text revision*. Arlington, VA: American Psychiatric Publishing, Incorporated.
- Barkley, T. W., & Myers, C. M. (2007). *Practice guidelines for acute care nurse practitioners*. Philadelphia: Saunders [Imprint].
- Boynton, R. W., Dunn, E. S., Stephens, G. R., & Pulcini, J. (2003). *Manual of ambulatory pediatrics*. Philadelphia: Lippincott Williams & Wilkins.
- Burns, C. E., Dunn, A. M., Brady, M. A., Barber Starr, N., & Blosser, C. (2008). *Pediatric primary care*. Philadelphia: Saunders [Imprint].
- Buttaro, T. M., Trybulski, J., Bailey, P. P., & Sandberg-Cook, J. (2007). *Primary care: A collaborative practice. Primary Care: Collaborative Practice Ser.* Philadelphia: Mosby [Imprint].
- Camp-Sorrell, D., & Hawkins, R. A. (2006). *Clinical manual for the oncology advanced practice nurse*. Pittsburgh: Oncology Nursing Society
- Chan, P. (2008). *Treatment guidelines for medicine and primary care, 2008 edition*. Mission Viejo, CA.: Current Clinical Strategies Publishing.
- Cloherty, J. P., Eichenwald, E. C. & Stark, A. R. (2008). *Manual of neonatal care*. Philadelphia: Lippincott Williams & Wilkins.
- Cooper, D. H., Krainik, A. J., Lubner, S. J. & Reno, H. (2007). *Washington manual of medical therapeutics*. Philadelphia: Lippincott, Williams and Wilkins.
- Dickey, R.P. (2007). *Managing contraceptive pill patients - 13th edition*. Dallas TX.: EMIS, Inc.
- Donn, S. M. (2003). *The Michigan manual of neonatal intensive care*. Philadelphia: Hanley & Belfus [Imprint].
- Dossey, B. M., & Keegan, L. (2008). *Holistic nursing: A handbook for practice*. Sudbury: Jones & Bartlett Publishers, Incorporated.
- Doyle, D., Hanks, G., Cherny, N., & Calman, K. (2005). *Oxford textbook of palliative medicine*. New York: Oxford University Press, Incorporated.
- Dunphy, L. M. (2004). *Management guidelines for nurse practitioners working with adults*. Philadelphia: F. A. Davis
- Dunphy, L. M., Winland-Brown, J. E., Porter, B. O., & Thomas, D. J. (2007). *Primary care: The art and science of advanced practice nursing*. Philadelphia: F. A. Davis Company.
- Eagle, K. A., Baliga, R. R., Armstrong, W. F., Bach, D. S., & Bates, E. R. (2008). *Practical cardiology*. Philadelphia: Lippincott Williams & Wilkins.

- Edmunds, M. W., & Mayhew, M. S. (2003). *Procedures for primary care practitioners*. Philadelphia: Mosby [Imprint].
- Fauci, A.S., Braunwald, E., Kasper, D.L., Hauser, S.L., Longo, D.L., Jameson, L., & Loscalzo, J. (2008). *Harrison's principles of internal medicine 17th edition*. New York: MacGraw-Hill Professional
- Ferrell, B. R., & Coyle, N. (2005). *Textbook of palliative nursing*. New York: Oxford University Press, Incorporated.
- Gibbs, R. S., & Danforth, D. N. (2008). *Danforth's obstetrics and gynecology*. Philadelphia: Lippincott Williams & Wilkins.
- Gonzalez, R. & Kutner, J.S. (2007). *Current practice guidelines in primary care 2008*. New York: McGraw-Hill Companies.
- Hawkins, J. W., Roberto-Nichols, D. M., & Stanley-Haney, J. L. (2008). *Guidelines for nurse practitioners in gynecologic settings*. New York: Springer Pub.
- Hay, W. W. (2005). *Current pediatric diagnosis & treatment*. New York: Lange Medical Books/McGraw-Hill, Medical Pub. Division.
- Hazzard, W. R. (2003). *Principles of geriatric medicine and gerontology*. New York: McGraw-Hill Professional.
- Hill, N. H. & Sullivan, L., (2004). *Management guidelines for nurse practitioners working with children and adolescents*. Philadelphia: F.A. Davis.
- Kaplan, H. I. and Sadock, B. J. (2005). *Pocket handbook of clinical psychiatry*. Philadelphia: Lippincott Williams and Wilkins.
- Kennedy-Malone, L., Fletcher, K. R., & Plank, L. M. (2003). *Management guidelines for nurse practitioners working with older adults*. Philadelphia: F. A. Davis Company.
- King, T. E., & Wheeler, M. B. (2007). *Medical management of vulnerable and underserved patients: principles, practice, and populations*. New York: McGraw-Hill Medical Pub. Division.
- Kliegman, R.M., Behrman, R.E., & Jenson, H.B. (2007). *Nelson textbook of pediatrics*. St. Louis, MO.: Elsevier Health Science.
- Kraus, D.M., Hurlburt Hodding, J. (2007). *Pediatric dosage handbook: international edition*. Hudson OH.: Lexi-Comp, Inc.
- Leppert, P. C., & Peipert, J. F. (2004). *Primary care for women*. Philadelphia: Lippincott Williams & Wilkins.
- Lewis, K. D., & Bear, B. J. (2009). *Manual of school health: a handbook for school nurses, educators, and health professionals*. St. Louis, Mo: Saunders.
- Lovell, W. W., Weinstein, S.W., & Morrissy, R.T. (2005). *Lovell and Winter's pediatric orthopedics*. Philadelphia PA.: Lippincott Williams & Wilkins.
- MacDonald, M.G., Ramasethu, J., & Vargas, A. (2007). *Atlas of procedures in neonatology*. Philadelphia, PA: Lippincott Williams & Wilkins.
- Martin, R.J., Fanaroff, A.A., & Walsh, M.C. (2005). *Fanaroff and Martin's neonatal-perinatal medicine: diseases of the fetus and infant, 2-volume set*. St. Louis, MO.: Elsevier Health Science.
- McInerney, T., Adam, H., Campbell, D., & Kamat, D. (2008). *AAP pediatric primary care*. Elk Grove Village, IL: American Academy of Pediatrics.

- Mulley, A. G., Goroll, A. H., & Mulley, A. G. (2006). *Primary care medicine: Office evaluation and management of the adult patient*. Primary Care Medicine ( Goroll ) Ser. Philadelphia: Lippincott Williams & Wilkins.
- Nathan, L., Goodwin, T. M., Decherney, A. H., & Laufer, N. (2007). *Current diagnosis and treatment, obstetrics and gynecology*. Current Obstetric and Gynecologic Diagnosis and Treatment Ser. New York: McGraw-Hill/Appleton & Lange [Imprint].
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**Revised: July 2008**

# NURSE PRACTITIONER SUMMARY OF REQUIREMENTS “AT A GLANCE”

(See Completing the Application Forms on page 13)

<b>If you are....</b>	<b>Submit to: New York State Education Department, Office of the Professions</b>						
	Form 1 and Fee	Form 2	Form 2B	Form 2C	Form 3	Form 4	Form 4NP
A graduate of a New York State registered, certificate-qualifying program, submit...	✓	✓					✓
A graduate of a program other than a New York State registered, certificate-qualifying program, submit...	✓	✓	✓	✓			✓
Certified as a nurse practitioner from an approved professional organization, submit...	✓		✓	✓	✓		✓
An applicant who completed alternative certificate requirements prior to 1989, submit...	✓	✓	✓	✓		✓	✓

\* Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is required only once.



# COMPLETING THE APPLICATION FORMS

## *for a Certificate as a Nurse Practitioner*

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### INSTRUCTIONS

Please type or print all information and sign all forms in black or blue ink. Original signatures are required on all forms.

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### FORM 1 - APPLICATION FOR A CERTIFICATE

**All applicants for a certificate** must complete this form and submit it with the \$85 fee for a certificate and initial registration directly to the Office of the Professions at the address at the end of Form 1. Make checks payable to the New York State Education Department. **NOTE: Your cancelled check is your receipt.**

You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. **Your signature on Form 1 must be notarized by a Notary Public.**

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### FORM 2 - CERTIFICATION OF PROFESSIONAL EDUCATION (For applicants who have completed a program registered by the State Education Department as qualifying for a certificate or a program determined by the Department to be equivalent; see pages 3-4.)

**This form must be submitted directly to the Office of the Professions by the professional school you attended. This form will not be accepted if submitted by the applicant or any party other than the school official.**

Section I: Complete this section of the form before sending the entire form to your school. Be sure to sign and date item 11.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

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### FORM 2B - VERIFICATION OF INSTRUCTION IN NEW YORK STATE AND FEDERAL LAWS RELATED TO PRESCRIPTIONS AND RECORD KEEPING (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

**This form must be submitted directly to the Office of the Professions by the school, institution or professional association where you completed instruction. This form will not be accepted if submitted by the applicant or any party other than the school, institution or professional association official.**

Section I: Complete this section of the form before sending the entire form to the school, institution or professional association where you completed instruction in New York State and federal laws relating to prescriptions and record keeping. Be sure to sign and date item 8.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

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### FORM 2C - VERIFICATION OF PHARMACOTHERAPEUTICS COURSE (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

**This form must be submitted directly to the Office of the Professions by the school, institution or professional association where you completed instruction. This form will not be accepted if**

**submitted by the applicant or any party other than the school, institution or professional association official.**

Section I: Complete this section before sending the entire form to the school institution or professional association where you completed a pharmacotherapeutic course, including instruction in drug management of clients in the nurse practitioner's specialty area. Be sure to sign and date item 8.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

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**FORM 3 - VERIFICATION OF NATIONAL NURSE PRACTITIONER EXAMINATION (For applicants seeking a New York State nurse practitioner certificate through a national certifying organization.)**

**This form must be submitted directly to the Office of the Professions from the national certifying organization that will verify your certification examination. The Office of the Professions will not accept this form if submitted by the applicant or any other party.**

Section I: Complete this section before sending the entire form to the national certifying organization to verify that you passed the nurse practitioner certification examination. Be sure to sign and date item 9.

Section II: The national certifying organization must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

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**FORM 4 - VERIFICATION OF EXPERIENCE (For applicants following pre-1989 alternative requirements for a certificate.)**

**This form is required within 90 days after commencement of practice.**

Section I: Complete this section of the form before sending the entire form to the physician who supervised your experience within the specialty for which you are seeking a certificate. Be sure to sign and date item 7.

Section II: The supervising physician must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

A separate Form 4 must be submitted by each physician with whom you worked with while acquiring the required experience.

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**FORM 4NP - VERIFICATION OF COLLABORATIVE AGREEMENT AND PRACTICE PROTOCOL (All applicants.)**

**Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is only required once.**

Section I: Complete this section of the form.

Section II & III: You and the initial collaborating physician with whom you have a practice agreement and practice protocol must complete these sections and return both pages of the form to the Office of the Professions at the address at the end of the form. Be sure to sign item 4 in Section III.

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**Completing Additional Forms**

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**FORM AD/NAME - ADDRESS/NAME CHANGE FORM**

You are required to notify us within 30 days of any name or address changes. Please read the instructions and complete the appropriate sections of this form.

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# NURSE PRACTITIONER

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## APPLICANT CHECKLIST

*Please complete and keep this checklist as a reminder of what forms you have filed and when you filed them. This is for your reference and should not be submitted with your application forms. **You should keep a copy of all application forms submitted.***

**CHECK (✓) AND DATE EACH STEP WHEN COMPLETED.**

\_\_\_\_\_ 1. Have you completed and sent the following to the Office of the Professions?

\_\_\_\_\_ A. FORM 1 - APPLICATION FOR A CERTIFICATE

\_\_\_\_\_ B. FEE (\$85) - FOR A CERTIFICATE AND INITIAL REGISTRATION

\_\_\_\_\_ 2. Have you completed and forwarded the following forms to the appropriate institution(s) or agencies? Keep copies of the requests so that you may check with them to be sure they have submitted the information.

\_\_\_\_\_ A. FORM 2 - CERTIFICATION OF PROFESSIONAL EDUCATION (For applicants who have completed a program registered by the State Education Department as qualifying for a certificate or a program determined by the Department to be equivalent; see pages 3-4.)

Sent to the following educational institutions:

Date sent


\_\_\_\_\_ B. FORM 2B - VERIFICATION OF INSTRUCTION IN NEW YORK STATE AND FEDERAL LAWS RELATED TO PRESCRIPTIONS AND RECORD KEEPING (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

Sent to the following school/institution/professional association:

Date sent


\_\_\_\_\_ C. FORM 2C - VERIFICATION OF PHARMACOTHERAPEUTICS COURSE (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

Sent to the following school/institution/professional association:

Date sent


\_\_\_\_\_ D. FORM 3 - VERIFICATION OF NATIONAL NURSE PRACTITIONER EXAMINATION (For applicants seeking a New York State nurse practitioner certificate through a national certifying organization.)

Sent to the following national certifying organization:

Date sent

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ E. FORM 4 - VERIFICATION OF EXPERIENCE (For applicants following pre-1989 alternative requirements for a certificate.) This form is required within 90 days after commencement of practice.

Sent to the following supervising physician(s):

Date sent

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ F. FORM 4NP - VERIFICATION OF COLLABORATIVE AGREEMENT AND PRACTICE PROTOCOL (all applicants) This form is required within 90 days after commencement of initial practice.

**TO SPEED PROCESSING OF YOUR APPLICATION:**

- **Submit your application for a New York State certificate in plenty of time to allow verifying organizations to send the required independent verifications to the Office of the Professions. This may take eight weeks or more.**
- Notify the Office of the Professions promptly of any address or name changes.
- Respond promptly to requests for additional information from the Office of the Professions.

# Nurse Practitioner Form 1

The University of the State of New York  
THE STATE EDUCATION DEPARTMENT  
Office of the Professions  
Division of Professional Licensing Services  
www.op.nysed.gov

## Department Use Only

### Application for a Certificate

Applicants Must Complete All Pages of This Application ***In Ink***

All applicants for a certificate must complete this form and submit it with the \$85 fee for a certificate and initial registration directly to the Office of the Professions at the address at the end of this form. You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. Form 1 must be notarized by a Notary Public.

1 

30	\$85	ER
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2 **Social Security Number**  
*(Leave this blank if you do not have a U.S. Social Security Number)*

3 **Birth Date** Month   Day   Year

4 **Print Name**  
*(This must be the same name as on your RN license.)*

Last   
First   
Middle

5 **Mailing Address** *(You must notify the Department promptly of any address or name changes.)*

Line 1   
Line 2   
Line 3   
City   
State  Zip Code   
Country/  
Province

NYS License Number

Date Issued

Initials

6 **Telephone/E-Mail Address**

Daytime phone

Area Code Phone

E-mail Address *(please print clearly)*

7 **New York State DMV ID Number**  
*(Driver or Non-Driver ID)*

*(Leave this blank if you do not have a New York State DMV ID Number)*

8 **New York State Registered Professional Nurse License Number:**

Name(s) under which credentialed (if different from above): \_\_\_\_\_

9 **Name as it appears on degree or other credentials (if different from above):** \_\_\_\_\_

10 **Nurse Practitioner specialty area for which you are applying:**

- Acute Care     Adult Health     College Health     Community Health     Family Health     Gerontology  
 Holistic Care     Neonatology     Obstetrics/Gynecology     Oncology     Pediatrics     Palliative Care  
 Perinatology     Psychiatry     School Health     Womens Health

11 **Identify the basis on which you are applying for a certificate. NOTE: A Form 1 & fee must be filed for each specialty area.**

Name at time of graduation (if different from above): \_\_\_\_\_

a. Completion of nurse practitioner educational program registered by the New York State Education Department as qualifying for a certificate. (File Form 2)

Program title (including specialty) Institution Date Graduated

b. Completion of nurse practitioner educational program determined to be equivalent to a registered program by the State Education Department as qualifying for a certificate. (File Form 2)

Program title (including specialty) Institution Date Graduated

c. Verification of passing a nurse practitioner examination administered by a national certifying organization. (File Form 3)

Examination Certifying agency Date Graduated

d. On the basis of alternative requirements for graduates of nurse practitioner programs prior to April 1, 1989

Experience (File Form 4)     Supplemental education program (File Form 2)

Please print clearly giving an accurate record of your educational preparation below. YOU MUST COMPLETE ALL INFORMATION FOR ALL SCHOOLS/COLLEGES/UNIVERSITIES ATTENDED AND DIPLOMAS AND/OR DEGREES RECEIVED OR YOUR APPLICATION WILL BE CONSIDERED INCOMPLETE. Attach additional sheets if necessary.

**Basic Nursing Program for R.N. Licensure**

Name of school: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Country: \_\_\_\_\_

Number of years attended: \_\_\_\_\_

Attendance from: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr. mo. day yr.

Graduation date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**All Postsecondary Higher Education except Nurse Practitioner Program(s)**

Name of School: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Country: \_\_\_\_\_

Major/Concentration: \_\_\_\_\_

Number of years attended: \_\_\_\_\_

Attendance from: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr. mo. day yr.

Title of Degree/Diploma/Certificate awarded (in the original language): \_\_\_\_\_

Date Degree/Diploma/Certificate awarded: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**Nurse Practitioner Program(s)**

Name of School: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Country: \_\_\_\_\_

Major/Concentration: \_\_\_\_\_

Number of years attended: \_\_\_\_\_

Attendance from: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr. mo. day yr.

Title of Degree/Diploma/Certificate awarded (in the original language): \_\_\_\_\_

Date Degree/Diploma/Certificate awarded: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**Certification by national certifying organizations or state**

Name of certifying organization or state: \_\_\_\_\_

Date originally certified: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Expiration date of current certification: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**13 Gender and Ethnicity: (This item is optional.)**

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

Gender:  Male

Female

Ethnicity:  White (not Hispanic)

Black (not Hispanic)

Asian

Hispanic

Native American

**14 Citizenship/Immigration Status:**

Federal law limits the issuance of professional licenses, registrations and limited permits to United States citizens or qualified aliens. To comply with this Federal law, complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

**I am:**

A. A United States citizen or National.

B. An alien lawfully admitted for permanent residence in the United States.

C. An alien granted asylum under Section 208 of the Immigration and Nationality Act.

D. A refugee granted asylum under Section 207 of the Immigration and Nationality Act.

E. An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least 1 year.

F. An alien whose deportation is being withheld under Section 241 (b)(3) of the Immigration and Nationality Act.

G. An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.

H. 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 United States: \_\_\_\_\_

I. I do not reside in the United States.

If you checked any of the boxes from B-H, enter your alien registration number or control number issued by the United States Citizenship and Immigration Services (USCIS):

USCIS number: \_\_\_\_\_

**QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) BY CALLING 1-800-375-5283, OR VISITING THEIR WEB SITE AT WWW.USCIS.GOV.**

**15 Child Support Obligation**

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support\*. **Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

**Check only A or B below. If you check B, you must check one of the five statements listed below it.**

A.  I am not under an obligation to pay child support  
**OR**

B.  I am under an obligation to pay child support and (please check only one of the following):

- I am current and **am not** four months or more in arrears in the payment of child support; or,
- I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- The child support obligation is the subject of a pending court proceeding; or,
- I am receiving public assistance or supplemental security income; or,
- None of the above four statements apply.

\* New York State General Obligations Law, section 3-503.

**16 Affidavit With Acknowledgment (Notarization required.)**

**Applicant**

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 and may result in criminal prosecution.

Signature of the applicant: \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**Notary**

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

On the \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature \_\_\_\_\_

Notary ID number \_\_\_\_\_

Expiration date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**Notary Stamp**

**Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department**



**Section II: Verification of Nurse Practitioner Program**

**Instructions to Registrar:** Please complete Section II and return both pages of this form **along with an official school transcript**, directly to the New York State Education Department at the address at the end of this form. **This form will not be accepted if returned by the applicant or any other party.**

**Note:** If the applicant has completed more than one program, a Form 2 must be submitted for each program.

- a) It is hereby verified that: \_\_\_\_\_  
*(Section I, item 6.)*
- has completed a program qualifying for certified nurse practitioner and the degree/diploma listed below has been awarded. The official program title completed by the applicant is as follows:
- Official program title: \_\_\_\_\_
- b) The program contained: \_\_\_\_\_ hours of classroom instruction and \_\_\_\_\_ hours of preceptorship with a nurse practitioner or physician.
- c) Degree/diploma awarded: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.
- d) The individual named has completed a pharmacotherapeutics component of not less than three semester hours or the equivalent, including instruction in drug management of clients in the nurse practitioner's concentration/specialty area.
- Yes  No
- e) The individual named has completed a pharmacotherapeutics component, including instruction in New York State and Federal laws related to prescriptions and record keeping.
- Yes  No

**Certification**

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.

Signature of Registrar: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Title or official position: \_\_\_\_\_

Institution: \_\_\_\_\_

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

**(SEAL)**

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.**







**Section II: Verification of Completion of Pharmacotherapeutics Course**

**Instructions to School/Institution/Professional Association:** Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of this form. **This form will not be accepted if returned by the applicant or any other party.**

1. It is hereby verified that: \_\_\_\_\_  

*(Section I, item 6)*

has completed pharmacotherapeutics instruction in drug management of clients in the nurse practitioner's specialty area of \_\_\_\_\_.
  
2. This course was  part of nurse practitioner program, or  
 supplementary course.
  
3. The inclusive date(s) of the course were: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ and \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.  

*mo. day yr. mo. day yr.*
  
4. The length of the course was: \_\_\_\_\_ or \_\_\_\_\_.  

*(Semester hours) (Clock hours)*
  
5. In this course, did the individual named receive instruction in New York State and Federal laws relating to prescriptions and record keeping?  
 Yes  No

**Attestation**

I hereby attest that to the best of my knowledge and belief the information in Section II is an accurate record of the completion of a course in pharmacotherapeutics by the individual named on this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  

*mo. day yr.*

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

Title or official position: \_\_\_\_\_

Institution: \_\_\_\_\_

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

**(SEAL)**

\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.**



**Section II: Verification of National Nurse Practitioner Examination**

**Instructions to National Certifying Organization:** Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of this form. **This form will not be accepted if returned by the applicant or any other party.**

1. It is hereby verified that: \_\_\_\_\_  
*(Section I, item 8)*  
has passed the nurse practitioner certification examination listed below.

2. Certification examination title: \_\_\_\_\_

Certificate awarded: (Title) \_\_\_\_\_

Certificate number: \_\_\_\_\_ Date initial certificate awarded: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Is this nurse currently certified?  Yes  No Expiration date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

3. Education program that was basis for admission to the examination:

Program \_\_\_\_\_

Entrance date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Completion date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr. mo. day yr.

Degree/diploma awarded: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Institution: \_\_\_\_\_

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

**Certification**

I hereby certify that to the best of my knowledge and belief the information in Section II is an accurate record of the examination results of the individual named on this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

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

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

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

**(SEAL)**

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.**



**Section II: Verification of Experience (Continued) - To be completed by the Supervising Physician**

**Summary Performance Evaluation**

		Satis- factory	Unsatis- factory	Does not apply
<b>A. Health Assessment</b>				
1.	Demonstrates skillful interviewing of clients.			
2.	Elicits an age-appropriate comprehensive health history.			
3.	Elicits and records information specific to the client's complaints (e.g., onset, timing, duration, location, associated symptoms, alleviating factors, quantity/intensity, etc.).			
4.	Performs a complete physical examination.			
5.	Demonstrates use of appropriate techniques of inspection, palpation, percussion, and auscultation throughout the examination.			
6.	Prepares client charts for review according to the facilities schedule.			
7.	Differentiates normal from abnormal findings.			
8.	Uses appropriate equipment accurately & efficiently when performing a physical examination.			
9.	Adapts the history and physical to meet the needs of individual clients.			
10.	Selects appropriate diagnostic tests to gather information necessary to evaluate the health status of a client.			
11.	Records information in a well-organized, concise manner.			
12.	Analyzes all data in order to formulate an assessment of the client's status and establish a plan of care.			
13.	Identifies specific health promotion/maintenance needs of clients and families.			
14.	Describes etiology, developmental considerations, pathogenesis and clinical manifestations of specific disease processes.			
15.	Correlates pathophysiology with client's signs & systems.			
16.	Correlates pathophysiology with laboratory data.			
17.	Demonstrates knowledge of pathophysiology of acute and chronic diseases or conditions commonly encountered in the practice setting.			
<b>B. Technical Skills</b>				
1.	Performs and interprets selected laboratory tests.			
2.	Performs technical skills specific to practice setting.			
3.	Performs therapeutic maneuvers skillfully.			
<b>C. Management of Acute and Chronic Illnesses</b>				
1.	Assesses and manages most common acute illnesses according to areas of preparation, age of client, legal parameters and current standards of practice.			
2.	Assesses and manages stable chronic illnesses according to areas of preparation, age of client, legal parameters and current standards of practice.			
3.	Identifies and manages emergency or crisis situations.			
4.	Collaborates with health team members and makes appropriate referrals.			
5.	Demonstrates diagnostic reasoning ability in formulating assessments.			

**Please attach a comment on the applicant's overall competence to provide primary care services in the designated specialty area.**

**Certification**

I certify that the information provided in Section II of this form is complete and accurate to the best of my knowledge and that I have personally supervised the person named in this form in the performance of the competencies listed above.

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

New York State medical license number:

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.**



**Section III: Practice Protocol**

**Instructions:** You must use an approved practice protocol text that is a standard publication. Please select a protocol text from the approved list (see application instructions, pages 8-9) and submit this form to the Department at the address at the end of the form, no later than 90 days after the commencement of practice.

1. List title, publisher, and date of publication of the approved protocol text.

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2. Location and description of practice site(s): (clinic, private office, HMO, etc.)

Practice Site		
Name	Address	Description

3. Description of practice including any mutually agreed upon exceptions:

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4. We hereby verify that we have a written a collaborative agreement and have selected a practice protocol(s).

Nurse Practitioner signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Collaborating Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.**

**ADDRESS/NAME CHANGE FORM**

**INSTRUCTIONS**

Use this form to report a change in your address and/or name. Please read these instructions carefully and be sure you complete the appropriate sections of this form. Please print clearly in ink.

- **For address changes only:** Complete Sections I, II, and IV. **For address changes only**, you may fax this form to the Records and Archives Unit at 518-486-3617 or provide the required information by e-mailing oparchiv@mail.nysed.gov. Your records will be updated. Currently registered licensed professionals will be sent a new registration certificate.
- **For name changes only:** Complete Sections I, III, and IV. **Name changes** must be accompanied by supporting documentation.

Acceptable supporting documentation includes:

A court order authorizing your name change, marriage certificate, or divorce papers **and** a copy of a photo ID in your new name.

**Or**

**Two (2)** of the following:

- A letter from the Social Security Administration indicating both your old and new names.
- Copies of both old and new driver's licenses.
- Copies of both old and new New York State non-driver photo ID cards.
- Copies of both old and new Social Security Cards.
- Copies of both old and new passports.
- Copies of both old and new U.S. Military photo ID cards.

Other forms of identification may be acceptable as supporting documentation. Please contact the Records/Archives Unit by calling 518-474-3817 Ext. 380 or by e-mailing oparchiv@mail.nysed.gov before submitting.

Be sure to sign and date Section IV. Currently registered licensed professionals will be sent a new registration certificate. Also, if you would like to replace your existing license parchment with one in your **new** name, check the appropriate box in Section III and enclose your **original parchment** (your original parchment will be letter sized, 8.5 x 11 inches, and will **not** have your address on it).

- **For address and name changes:** Complete all sections.

Licensed professionals can check the Office of the Professions' Web site at www.op.nysed.gov to verify your name, city, state, registration expiration date, and license number on record.

**NOTE:** Important information and registration renewals will be sent to the address on file for you. **You must notify the Department in writing within 30 days if your address or name changes.**

**Section I: Your General Information**

1. Name (currently on record): \_\_\_\_\_

2. Social Security Number:        Birth Date: Month   Day   Year

Telephone: Home: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

3. Are you reporting an address and/or name change?  address change  name change  both

4. Effective date of change: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **(Note: Changes cannot be accepted until after the effective date.)**

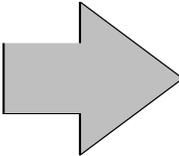
5. Licensure status in New York State:

I am an applicant for licensure in New York State for the licensed profession(s) of: \_\_\_\_\_

I am currently licensed in New York State in the profession(s) of: \_\_\_\_\_ (see list of professions on page 2)

\_\_\_\_\_ New York State license number:

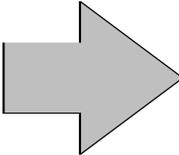
**Section II: Address Change (please print)**

Information <u>Currently On Record</u>		New Information
Apt./Bldg. _____		Apt./Bldg. _____
Street _____		Street _____
City _____		City _____
State _____		State _____
Zip Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Zip Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Province or Country (if not U.S.) _____	Province or Country (if not U.S.) _____	

Is this new address a business address?  Yes  No

**Failure to answer this question will result in your address being deemed a business address and, therefore, public information.**

**Section III: Name Change (please print)** If you are reporting a name change, please sign using your **NEW** name in Section IV. **If you are currently registered you will receive a new registration certificate.**

Information <u>Currently On Record</u>		New Information
Last Name _____		Last Name _____
First Name _____		First Name _____
Middle or Initial _____		Middle or Initial _____

Check here if you wish to have your existing license parchment replaced with one in your **NEW** name. Enclose your **original parchment** and a **\$10 check or money order** made payable to the New York State Education Department with your request. You will be sent a new parchment. **Note:** your **original** parchment will be letter sized, 8.5 x 11 inches, and will **not** have your address on it.

**Section IV: Affidavit**

*I declare and affirm that the statements above are true, complete, and correct. I understand that any false or misleading information in, or in connection with, my application or this notification may be cause for denial or loss of licensure and may result in criminal prosecution.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Professional Titles Licensed Under Education Law**

(See item #5 on page 1 of the form.)

- |  |  |  |
|--|--|--|
| Acupuncturist<br>Architect<br>Athletic Trainer<br>Audiologist<br>Certified Clinical Laboratory Technician<br>Certified Dental Assistant<br>Certified Histological Technician<br>Certified Public Accountant<br>Certified Shorthand Reporter<br>Chiropractor<br>Clinical Laboratory Technologist<br>Creative Arts Therapist<br>Cytotechnologist<br>Dental Hygienist<br>Dentist<br>Dietitian/Nutritionist<br>Interior Designer | Landscape Architect<br>Land Surveyor<br>Licensed Clinical Social Worker<br>Licensed Master Social Worker<br>Licensed Practical Nurse<br>Marriage and Family Therapist<br>Massage Therapist<br>Medical Physicist<br>Mental Health Counselor<br>Midwife<br>Nurse Practitioner<br>Occupational Therapist<br>Occupational Therapy Assistant<br>Ophthalmic Dispenser<br>Optometrist<br>Perfusionist<br>Pharmacist | Physical Therapist<br>Physical Therapist Assistant<br>Physician<br>Podiatrist<br>Polysomnographic Technologist<br>Professional Engineer<br>Psychoanalyst<br>Psychologist<br>Public Accountant<br>Registered Physician Assistant<br>Registered Professional Nurse<br>Registered Specialist Assistant<br>Respiratory Therapist<br>Respiratory Therapy Technician<br>Speech-Language Pathologist<br>Veterinarian<br>Veterinary Technician |
|--|--|--|

**Applicants**  
**mail to**

New York State Education Department, Office of the Professions, Division of Professional Licensing Services,  
(insert name of profession from above list) Unit, 89 Washington Avenue, Albany, NY 12234-1000.

**Licensees**  
**mail to**

New York State Education Department, Office of the Professions, Division of Professional Licensing Services,  
Records and Archives Unit, 89 Washington Avenue, Albany, NY 12234-1000.



**The State Education Department  
Office of the Professions  
Division of Professional Licensing Services  
89 Washington Avenue  
Albany, NY 12234-1000**