

Colorado Division of Registrations  
**State Board of Nursing—LPN IV Authority**  
1560 Broadway, Suite 1350  
Denver, CO 80202  
Phone: (303) 894-2430  
FAX: (303) 894-2821  
[www.dora.state.co.us/registrations](http://www.dora.state.co.us/registrations)

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## **APPLICATION FOR REINSTATEMENT—LPN IV AUTHORITY**

### **APPLICANT INSTRUCTIONS**

**Basic Requirements.** All applicants must hold a current and valid Colorado Licensed Practical Nurse license in good standing and without discipline OR a current and valid Compact Multi-state Licensed Practical Nurse license in good standing and without discipline. Information about the Nurse Licensure Compact, including a current list of Compact states, is available on the Board's website at [www.dora.state.co.us/nursing/licensing/compact.htm](http://www.dora.state.co.us/nursing/licensing/compact.htm). Requirements for IV authority are outlined in Chapter IX—Rules and Regulations for the Licensed Practical Nurse in Relation to IV Authority, available online at [www.dora.state.co.us/nursing](http://www.dora.state.co.us/nursing).

In compliance with the Michael Skolnik Medical Transparency Act of 2010, licensees are required to complete an online Healthcare Professions Profile on our website at [www.dora.state.co.us/hppp](http://www.dora.state.co.us/hppp).

**About the Application.** This application is to be completed by you and returned to the State Board of Nursing. All questions on the application are mandatory, and all supporting documentation and the appropriate fee must be received before the application is considered complete. You may copy as many forms as needed; however, each form submitted must be an original, completed in ink or typed. Keep a copy of the completed application for your records.

**Application Expiration.** Your application will be kept on file for one (1) year from date of receipt at the State Board of Nursing. Your file and all supporting documentation will be purged if you do not submit required documents and complete the application process in one year. At that time, you will be required to submit a new, current application, all supporting documentation, and the current application fee.

**Social Security Number is Required.** Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit his/her Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. The affidavit is available on our website at [www.dora.state.co.us/registrations/SSNAffidavit.pdf](http://www.dora.state.co.us/registrations/SSNAffidavit.pdf), or you may call (303) 894-7800 to request that one be mailed to you.

**Disclosure of Addresses.** Consistent with Colorado law, all addresses and phone numbers on record with the Division are public record and must be provided to the public when requested. It is your responsibility to keep your address and contact information up-to-date in our database. All letters, renewal notices, and licenses are mailed to the last known address of record. If your address is not current, it is possible you will not receive important documents. You can change your address online by using Registrations Online Services at [www.doradls.state.co.us](http://www.doradls.state.co.us).

**Each Application Requires Its Own Documentation.** You must provide all documentation requested in these instructions even if you have submitted the same or similar documentation with previous applications. Each application must stand on its own merit. All supporting documentation must be provided by you, the applicant, and be attached to this application, unless otherwise noted.

## APPLICANT CHECKLIST

### To reinstate your LPN IV Authority:

- Complete the attached application.** Return the completed application and all supporting documentation to the State Board of Nursing.
- Enclose the non-refundable application processing fee.** See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and **made payable to State of Colorado**. All fees are non-refundable and subject to change every July 1.
- Provide documentation of any name change.** If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).
- Complete a Healthcare Professions Profile.** In compliance with the Michael Skolnik Medical Transparency Act of 2010, you are required to complete an online profile on our website at [www.dora.state.co.us/hppp](http://www.dora.state.co.us/hppp). You cannot start your profile until the Division of Registrations receives your application and enters it into our database. Allow 10 days from the date your application was mailed before accessing the website. If you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at [hppp@dora.state.co.us](mailto:hppp@dora.state.co.us) or (303) 894-5942.

### If your IV Authority has been expired for more than two (2) years:

- Complete the Competency to Practice section of this application and submit required documentation.** You must demonstrate competency to practice and meet all current requirements for IV authority.

*For questions about the application process, call (303) 894-2415.*

### Return your completed application packet and all supporting documentation to:

Division of Registrations  
State Board of Nursing—LPN IV Authority  
1560 Broadway, Suite 1350  
Denver, CO 80202

**Colorado Department of Regulatory Agencies**  
 Division of Registrations  
 1560 Broadway, Suite 1350  
 Denver, CO 80202

**Licensee/Applicant Full Legal Name**

Last	First	Middle	Suffix

**Colorado Professional or Occupational License/Certification/Registration Number:** \_\_\_\_\_  
 (if already licensed)

**Professional or Occupational License/Certification/Registration type applying for:** \_\_\_\_\_

**AFFIDAVIT OF ELIGIBILITY**

Pursuant to H.B. 06S-1009, C.R.S. 24-34-107, ALL applicants for original licensure\* or licensees renewing or reinstating a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

*\*The word "licensure" is used as a general term. While most of the professions and occupations are licensed, others may be certified, registered, or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.*

**Section A: LAWFUL PRESENCE in the United States**

1.  I am a U.S. citizen. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
2.  I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
3.  I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)
  - a.  I am a U.S. citizen, not physically present or employed in the United States.
  - b.  I am a Foreign National, not physically present or employed in the United States.

**Section B: SECURE AND VERIFIABLE DOCUMENTS**  
 Select ONE document in this section if you checked 1 or 2 in Section A.

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
<input type="checkbox"/> Driver's license or permit				
<input type="checkbox"/> Government issued ID card				
<input type="checkbox"/> Valid U.S. military ID/common access card				
<input type="checkbox"/> Colorado Department of Corrections inmate ID				
<input type="checkbox"/> Tribal ID card				
<input type="checkbox"/> U.S. passport				
<input type="checkbox"/> Certificate of Naturalization				

**Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)**

<b>Government Issued Identification</b>	<b>Name of state agency or federal agency that issued the document</b>	<b>Full name as shown on driver's license or state/federal issued ID</b>	<b>License/ID Number</b>	<b>Expiration Date (mm/dd/yyyy)</b>	
<input type="checkbox"/> Certificate of (U.S.) Citizenship					
<input type="checkbox"/> Valid Temporary Resident card					
<input type="checkbox"/> Valid I-94 issued by Canadian government					
<input type="checkbox"/> Valid I-94 with refugee/asylum stamp					
<input type="checkbox"/> Valid I-766 (Employment Authorization Card)			<b>Issuing federal agency:</b>		
<b>Name on card</b>	<b>Alien Number (A#)</b>	<b>Card Number</b>	<b>Valid from (mm/dd/yyyy)</b>	<b>Expires (mm/dd/yyyy)</b>	
<input type="checkbox"/> Valid I-551 (Resident Alien or Permanent Resident Card)			<b>Issuing federal agency:</b>		
<b>Name on card</b>	<b>Alien Number (A#)</b>	<b>Country of birth</b>	<b>Card expires (mm/dd/yyyy)</b>	<b>Resident since (mm/dd/yyyy)</b>	
<input type="checkbox"/> Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94					
<b>Issuing foreign country</b>	<b>Passport Number</b>	<b>Visa Number</b>	<b>Visa Class (ex.: J-1, P-1, H-1B, etc.)</b>	<b>Date of entry (mm/dd/yyyy)</b>	<b>Until date (mm/dd/yyyy)</b>
<input type="checkbox"/> Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa					
<b>Issuing foreign country:</b>			<b>Passport Number:</b>		

**Section C: ATTESTATION**

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.
- I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

\_\_\_\_\_  
Print Full Legal Name

\_\_\_\_\_  
Signature (Full Name)

\_\_\_\_\_  
Date

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*.

**PART 1—LICENSE INFORMATION**

<b>I hold an ACTIVE (check ONE):</b>		
<input type="checkbox"/> Colorado LPN License Number:		Expiration Date:
<input type="checkbox"/> Compact Multi-state LPN License Number:	State:	Expiration Date:
Colorado IV Authority Number:		Expiration Date:

**PART 2—APPLICANT INFORMATION**

<b>Name:</b> Last:	First:	Middle:	Suffix:
<b>Previous Name(s):</b>			
<b>Social Security Number:</b>	<b>Date of Birth</b> (mm/dd/yyyy):	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Place of Birth</b> (city and state, or foreign country):			
<b>Mailing Address:</b>	PO Box, Street:	City, State, Zip:	
This is a <input type="checkbox"/> Home <input type="checkbox"/> Business			
<b>Daytime Telephone Number:</b> (     )	<b>E-mail Address:</b>		
	Preferred method for communication: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail		

**PART 3—PRACTICE INFORMATION**

Since the date your IV authority expired, have you practiced intravenous therapy as a Licensed Practical Nurse in the state of Colorado?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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**\*Social Security Number Disclosure:** Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's social security number. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support under § 14-14-113 and § 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation for identification purposes only. Your social security number will not be released for any other purpose not provided for by law.

**OFFICE USE ONLY**    LPN IV Authority Number: \_\_\_\_\_    Date Approved: \_\_\_\_\_

**PART 4—DECLARATION OF PRIMARY STATE OF RESIDENCE**

“Primary state of residence” is defined as the state of a person’s declared fixed permanent and principal home for legal purposes; domicile. **You may be required to provide proof of residency.**

I declare that the state of \_\_\_\_\_ is my primary state of residence and that such constitutes my permanent and principal home for legal purposes.

**Note:** If you declare Colorado as your primary residence, you must obtain, reactivate, or reinstate a Colorado LPN license prior to applying for IV authority.

Primary Residence Physical Address:	Street: City, State, Zip:
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**PART 5—COMPETENCY TO PRACTICE**

**Has your IV Authority been expired more than two (2) years?**

- NO.** Your application is complete. Sign, date, and submit your application to the State Board of Nursing.
- YES.** Provide proof of successful completion of IV therapy training from a Board-approved LPN program OR a Board-approved LPN IV therapy training program.
  - If your IV Therapy education and training was completed in Colorado, include the following with your application:
    - An LPN IV Authority Competency Checklist (attached) completed in its entirety, including original signature and license information, by an RN Evaluator and returned to you in an **official sealed envelope**. An RN Evaluator must be one of the following:
      - Program director (must be an RN) from a Board-approved Practical Nursing education program with first-hand knowledge of your IV therapy skills/training; or
      - IV therapy course instructor (must be an RN) from a Board-approved Practical Nursing education program with first-hand knowledge of your IV therapy skills/training.
  - If your IV Therapy education and training was completed outside of Colorado, include the following with your application:
    - An official transcript or certificate of completion reflecting your successful completion of IV training and issued to you in an **official sealed envelope**; and
    - A course description itemizing the content of the IV training course; and
    - An LPN IV Authority Competency Checklist (attached) completed in its entirety, including original signature and license information, by an RN Evaluator and returned to you in an **official sealed envelope**. An RN Evaluator must be one of the following:
      - Program director (must be an RN) from a Board-approved Practical Nursing education program with first-hand knowledge of your IV therapy skills/training; or
      - IV therapy course instructor (must be an RN) from a Board-approved Practical Nursing education program with first-hand knowledge of your IV therapy skills/training; or
      - RN employer/supervisor. **Note:** This form may not be completed by a current or previous employer/RN supervisor with whom the applicant has completed “on the job” training.

APPLICANT NAME: \_\_\_\_\_

**PART 5—COMPETENCY TO PRACTICE (continued)**

**IV Authority expired more than two years (continued):**

Program from which you obtained your Practical Nursing education:

Name of Program and Institution	Location (city and state)	Date Completed (mm/yyyy)

Program(s) from which you obtained your LPN IV Therapy education training, if applicable:

Name of Program and Institution	Location (city and state)	Date Completed (mm/yyyy)

Was this IV therapy training approved by a state Board of Nursing?  YES  NO

If **YES**, name of Board and State: \_\_\_\_\_

**ATTESTATION**

In accordance with C.R.S. 18-8-503 and C.R.S. 18-8-501(2)(a)(I), false statements made herein are punishable by law. I understand that under the Nurse Practice Act, providing false information to the Board is grounds for denial, suspension or revocation of a Practical Nurse license.

I state under penalty of perjury, as defined in C.R.S. 18-8-503, that the information contained in this application is true and correct to the best of my knowledge.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

# LPN IV AUTHORITY COMPETENCY CHECKLIST

## SECTION 1: To be completed by the Applicant

### APPLICANT

Name: Last:	First:	Middle:	Suffix:
LPN License Number:		State of Issuance:	
Name of Program:			
Program Address: PO Box, Street: City, State, Zip:			

## SECTION 2: To be completed by the RN Evaluator

The above-named applicant is submitting an application for LPN IV Authority to the Colorado Board of Nursing. Please verify this applicant's knowledge and competency in the areas below.

**I verify the applicant's knowledge regarding:**

• Legal implications / scope of practice	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Role of LPN in IV therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Related anatomy and physiology	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Anatomical site selection for IV insertion	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Fluids and electrolytes	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Commonly used IV fluids	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Hazards and complications of IV therapy – local and systemic	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Psychological aspects of venipuncture	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Infection control measures	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Types of venous access devices	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Monitoring venous access device site	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Dressing and cap changes	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Initiating, monitoring, regulating, replacing and discontinuing IV fluids	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Use of appropriate equipment including IV pumps	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Drug incompatibilities	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Administering pre-mixed vitamins and electrolytes	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Pharmacology of heparin and antibiotics	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Administration of pre-mixed IV antibiotics	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Flushing venous access devices to maintain venous patency	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Collection of venous blood specimens for tests	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Use of appropriate equipment for collection of venous specimens	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Nursing care, intervention, reporting, documentation r/t IV therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Nursing care, intervention, reporting, documentation r/t venous blood sampling	<input type="checkbox"/> YES <input type="checkbox"/> NO

**SECTION 2: To be completed by the RN Evaluator (continued)**

I verify the applicant's clinical competency based on clinical practice or simulated practice regarding:

• Peripheral short catheter insertion on adult clients	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Initiation and monitoring of IV fluid administration on adult clients through peripheral venous access devices	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Initiation and monitoring of IV fluid administration on adult clients through central venous access devices	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Flushes into venous access devices to maintain venous patency for adult clients	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Administration of pre-mixed antibiotics via venous access devices to adult client	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Utilization of IV pumps	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Peripheral venous blood sampling on adult clients	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Discontinuation of one peripheral short device	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Documentation of nursing actions and observations	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Sterile dressing change on <b>central</b> venous access device	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Blood collection from a central venous access device	<input type="checkbox"/> YES <input type="checkbox"/> NO

**Comments:**

Dates the applicant attended your program: \_\_\_\_\_ to \_\_\_\_\_.  
mm/yyyy mm/yyyy

RN EVALUATOR			
Name: Last:	First:	Middle:	Suffix:
RN License Number:		State of Issuance:	
Signature:			Date:

*For questions about the completion of this form, call (303) 894-2415.*

**This form must be mailed directly to the following address by the RN Evaluator:**

Division of Registrations  
**State Board of Nursing—LPN IV Authority**  
 1560 Broadway, Suite 1350  
 Denver, CO 80202