

REINSTATEMENT APPLICATION—PRACTICAL NURSE

APPLICANT INSTRUCTIONS

**Only complete this application if your Colorado PN license is in Expired status.
If your license is in Inactive status, you must complete a Reactivation application.**

Nurse Licensure Compact. The Nurse Licensure Compact became effective in Colorado on October 1, 2007, allowing nurses licensed in Colorado to practice in other compact states. A nurse may hold only one compact license and it must be issued by his/her state of primary residence. **If you declare your primary state of residence to be a compact state other than Colorado, you should not apply for licensure in Colorado and your application will be returned to you.** Upon issuance of a Colorado license, your other compact state license(s) will expire. You may be required to provide proof of residency, which may include a Colorado driver's license, voter registration or income tax return. If you declare a non-compact state as your state of primary residence, and you meet all other requirements for licensure in Colorado, you will receive a single-state license valid for practice only in Colorado. For a list of states participating in the Compact or additional information about the Compact go to our website at www.dora.state.co.us/nursing

Mandatory Practice Act. Colorado has a mandatory practice act, which means that you may not practice as a Practical Nurse in this state without a Colorado or other compact state license. Submission of this application does not guarantee licensure. Therefore, do not make life or career decisions based on the probability that you may receive a license. Plan ahead for the time it will take to receive and review all required documents and complete our evaluation.

Basic Requirements. Requirements for licensure are outlined in the Colorado Revised Statutes, specifically 12-38-101; the Board's rules; and the Board's policies. These documents are available online at 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.

Retired Volunteer Nurse Status. You may apply for reinstatement as a Retired Volunteer Nurse if you are at least 55 years of age and you meet the competency requirements as outlined in Board Rule 5.6. You may not accept compensation for nursing tasks performed.

About the Application. This application is to be completed by you and returned to the Office of Licensing. All questions on the application are mandatory, and all supporting documents must be submitted with the application. The application forms must be completed in original ink or typed. Keep a copy of the completed application and supporting documents for your records.

Application Expiration. Your application will be kept on file for one (1) year from the date of receipt in the Division. Your file and all supporting documentation will be purged if you do not submit required documents and complete your application process in one year. You will need to submit a new application packet and fee after that time.

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, or you may call (303) 894-7800 to request that one be mailed to you.

Name Change Documentation. 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).

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, phone numbers 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.

License Expiration Grace Period for New Applicants. Practical Nurse license expiration dates are August 31 of even-numbered years. All new applicants who are issued a license within 120 days of the upcoming renewal expiration date will be issued a license with the subsequent expiration date. For example, licenses issued between May 1, 2010 and August 31, 2010 will reflect a license expiration date of August 31, 2012. Licenses issued prior to May 1, 2010 will reflect an expiration date of August 31, 2010 and must renew in the upcoming renewal period.

IV Authority. Reinstatement of your LPN license does not reinstate your IV Authority. You must submit a separate application after your LPN license is reinstated. Applications are available online at www.dora.state.co.us/nursing/licensing/IVauthority.htm.

APPLICANT CHECKLIST

To apply for reinstatement of your Practical Nurse license:

- Complete the attached Reinstatement Application.** Return the completed application and all supporting documentation to the Office of Licensing.
- 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.
- Complete and return the attached Affidavit of Eligibility form.** Pursuant to C.R.S. 24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.
- 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. 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 or (303) 894-5942.
- If your license has been expired for more than two years, you must demonstrate competency to practice.** Refer to the Competency to Practice section of the application for detailed instructions.

Return your completed application packet and all supporting documentation to:

Division of Registrations
Office of Licensing—Nursing
1560 Broadway, Suite 1350
Denver, CO 80202



IMPORTANT NOTICE

TO: All Applicants

FROM: Rosemary McCool, Director, Division of Registrations

SUBJECT: Licensure and Criminal History

Thank you for your interest in becoming a licensed* professional within the Division of Registrations. Before you submit your application, please be aware of a few facts regarding criminal conduct, convictions, and disciplinary actions in other states.

The mission of the Division of Registrations is “public protection through effective licensure and enforcement.” One way the Division safeguards consumers is by issuing licenses to fully qualified, competent, and ethical applicants.

During the licensing process – and depending on the specific application – the Division will ask whether you have ever been disciplined in any state, arrested, charged, convicted, or pled guilty to a crime. An arrest, subsequent criminal conviction, or disciplinary action is not an automatic disqualification from licensure. Instead, the appropriate board or program will look at the facts surrounding the criminal conduct and disciplinary action to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. One thing you must do to obtain the privilege is to be completely honest on your application.

Be sure to list all relevant complaints, disciplinary actions, arrests, charges, or convictions in response to the licensure questions. Failure to fully disclose could constitute grounds alone for denial of your application or revocation of your license. More important, avoid some of the common excuses we have heard from people who failed to disclose, such as:

- My attorney told me I didn’t have to disclose the criminal conduct or disciplinary actions.
- I didn’t think the prior conduct had anything to do with the profession.
- I didn’t think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn’t think it was subject to disclosure because I received a deferred sentence/judgment.

Remember, there is no excuse not to disclose disciplinary actions and criminal conduct. Even after licensure, you are still required to notify your professional licensing board or program about subsequent convictions and disciplinary actions in other states.

The Division conducts audits of its licensing database against several criminal and national disciplinary databases. This allows the Division to verify the truthfulness of your application and track subsequent criminal and disciplinary conduct after initial licensure. Keep in mind, you will not necessarily be revoked or denied a license if you have been disciplined, arrested, charged or convicted, but you will most likely be denied or revoked if you fail to disclose it.

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



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)

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"/> 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)			Issuing federal agency:		
Name on card	Alien Number (A#)	Card Number	Valid from (mm/dd/yyyy)	Expires (mm/dd/yyyy)	
<input type="checkbox"/> Valid I-551 (Resident Alien or Permanent Resident Card)			Issuing federal agency:		
Name on card	Alien Number (A#)	Country of birth	Card expires (mm/dd/yyyy)	Resident since (mm/dd/yyyy)	
<input type="checkbox"/> Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94					
Issuing foreign country	Passport Number	Visa Number	Visa Class (ex.: J-1, P-1, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)
<input type="checkbox"/> Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa					
Issuing foreign country:			Passport Number:		

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

Select a license status:

- I wish to reinstate with full **ACTIVE** status. Fee: **\$104**
- I wish to reinstate with **RETIRED VOLUNTEER NURSE** status. Fee: **\$20**
(To be eligible for Retired Volunteer Nurse status, you must be 55 years of age or older, must meet the competency requirements outlined in Board Rule 5.6, and may not accept compensation for nursing tasks performed as a volunteer.)

Colorado Practical Nurse License Number: _____ Date License Expired: _____

PART 1—APPLICANT INFORMATION

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

PART 2—LICENSE INFORMATION

A. Since the date your Colorado nursing license expired, have you been practicing as a Practical Nurse in the state of Colorado? YES NO

Do you hold an active Compact multi-state license? If YES, provide license information. YES NO

State	Issue Date	Expiration Date	Disciplinary action against license?	Is this license current/active?	Have you worked on this license in the past 2 years?
			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

B. List each jurisdiction, other than Colorado, in which you hold or have ever held any health care license. (If needed, attach an additional sheet using the same format.) If not applicable, enter N/A.

Type of license	State/Country	License Number	Year license issued	Disciplinary action against license?	Is this license current/active?	Have you worked on this license in the past 2 years?
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

***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.

PART 3—SCREENING QUESTIONS

You must provide the following for each “YES” response to the screening questions below:

- An explanation, signed and dated by you, of your behavior or practice that led to the occurrence, including:
 - Date(s) of event/offense
 - Description of event/offense
 - Location/court
 - Current status/outcome

You may be required to provide the following:

- Copies of legal documents relating to the event/offense.
- Copies of legal documents indicating your compliance with any requirements imposed upon you.

- | | | |
|---|------------------------------|-----------------------------|
| 1. Has any nursing or other health care license held by you been denied, revoked, suspended, reprimanded, fined, surrendered, restricted, limited, or placed on probation in any state other than Colorado or in any territory of the United States? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Are you under investigation or is a disciplinary action pending against your nursing license or other health care license in any state or territory of the United States? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Have you received notification from the Department of Health and Human Services, Office of the Inspector General, that you have been excluded from participation in Medicare, Medicaid or any federal health care programs based on program related crimes and discipline? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Have you ever been convicted, entered a plea of guilty, nolo contendere, or no contest for any felony, misdemeanor or petty offense? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Have you ever been convicted, pled no contest/nolo contendere, or had a court accept a plea to a criminal motor vehicle offense of DUI/DWI/DWAI/OWI or any traffic offense involving drugs or alcohol? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Has any final judgment, settlement or arbitration award for malpractice been paid by you or on your behalf? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. In the last five years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a practical nurse safely and competently, such as bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Do you now abuse or excessively use, or have you in the last five years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a practical nurse safely and competently? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Have you been terminated or permitted to resign in lieu of termination from a nursing or other health care position because of your use of alcohol or use of any controlled substance, habit-forming drug, prescription medication, or drugs having similar effects? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Have you been arrested for an alcohol or drug-related offense other than stated in question No. 5? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

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.**

NOTE: If you declare your primary state of residence to be a compact state other than Colorado, you should not apply for licensure in Colorado and your application will be returned to you.

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

Primary Residence Physical Address:	Street: City, State, Zip:
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PART 5—DECLARATION OF STATE(S) OF CURRENT PRACTICE

Upon licensure in Colorado, I may practice in the state(s) of:

Colorado (strike through if not applicable) _____

Attach additional sheets if necessary.

I will practice exclusively at a government / military facility and am requesting a Colorado single-state license.

PART 6—COMPETENCY TO PRACTICE

Has your Colorado license been expired more than two (2) years?

- NO.** Part 6 is complete. Sign, date, and submit your application to the Office of Licensing.
- YES.** You must demonstrate competency by one of the following methods. Check either Option A or Option B below and follow the corresponding instructions.

This section – and all attached forms referenced in this section – applies only to individuals whose license has been expired for more than two (2) years. Competency to practice may be established by one of the following methods:

Check either Option A or Option B

- A.** Demonstration of the active practice of nursing in another state, federal facility, or U.S. territory during the two (2) years preceding the filing of this reinstatement application. If you select this option, you are attesting that you have worked during the two (2) years preceding the submission of this application and you must submit the following with your application:
- Verification of Active Licensure. Contact the state in which you hold an active license, or a license that has been expired less than two (2) years, to determine their fee and which of the verification forms you need to submit.
 - ▶ For participating states, you must apply for NURSYS Verification through the [NURSYS website](http://www.nursys.com) (a current list of participating states can be found at www.nursys.com) **OR**
 - ▶ For non-participating states, you must complete and submit a Request for Verification of Nursing License form (attached).

This process may take anywhere from two weeks to several months, depending on your circumstances and how quickly you submit the supporting documentation required. You can help speed this process by completing the application thoroughly, supplying all the required supporting documents, and responding quickly to requests for information made by staff.

—OR— (continued on next page)

PART 6—COMPETENCY TO PRACTICE (Continued)

B. Successfully completing refresher courses as defined in Nursing Board Rule 5.6. If you select this option, you must complete all three of the following steps:

1. Register for a Board-approved nursing education program / refresher course.
2. Within the guidelines of your chosen program / course, locate a qualified clinical agency (acute, subacute, skilled) to obtain the required, unpaid supervised clinical experience. Submit a completed Non-Traditional/Refresher Program Instructor/Preceptor Agreement (attached) with your application and fee to the Office of Licensing, 1560 Broadway, Suite 1350, Denver, CO 80202.

Upon review and approval of the application and Non-Traditional/Refresher Program Instructor/Preceptor Agreement, your license will be reinstated in a Restricted Status, valid only for the purpose of completing the clinical experience. Plan ahead for the time it will take to receive and review all required documents and complete our evaluation.

This process must be completed prior to the start of the clinical training.

3. Upon completion of steps 1 and 2 above, provide evidence of having completed all requirements as follows:
 - Obtain an official transcript or certificate in its official sealed envelope indicating completion of the Board-approved nursing education program/refresher course;
 - Obtain an original completed Non-Traditional/Refresher Program Skills Checklist (attached) from your Preceptor in an official sealed envelope; and
 - Submit both documents in their unopened, sealed envelopes to the Office of Licensing.

Upon review and approval of both documents, the restriction will be removed from your license and a new license copy will be issued in an Active or Retired Volunteer Status, as appropriate, if all other licensing requirements are met.

ATTESTATION

I state under penalty of perjury in the second degree, 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. In accordance with C.R.S. 18-8-501(2)(a)(I), false statements made herein are punishable by law and may constitute violation of the practice act.

Applicant Signature

Date

USE THIS FORM IF YOUR STATE OF LICENSURE IS NOT LISTED WITH NCSBN/NURSYS

For a list of Nursys participating states, please see <https://www.nursys.com>

Colorado Division of Registrations

Office of Licensing–Nursing

1560 Broadway, Suite 1350

Denver, CO 80202

Phone: (303) 894-7800 / FAX: (303) 894-7693

www.dora.state.co.us/registrations

REQUEST FOR VERIFICATION OF NURSING LICENSE

You are responsible for ensuring your state of licensure sends verification to the Colorado Office of Licensing.

You are also responsible for ensuring its receipt by the Colorado Office of Licensing.

PART 1: To be completed by the APPLICANT and forwarded to state of active licensure with fee determined by that state.

Last Name First Middle

Previous Name(s)

Mailing Address (PO Box, Street, City, State, & ZIP)

Social Security Number Date of Birth

Licensed under the name of Year of License Original license number

I hereby authorize all Boards of Nursing to release my license data to the Colorado Board of Nursing.

Applicant Signature

Date

PART 2: To be completed by the LICENSING BOARD of the state of active licensure and sent to the Colorado Office of Licensing.

Licensed by Exam:

	State Board Exam PN	NCLEX PN
Score		
Series/Form		

Licensed by Endorsement: State: _____

Active License/Registration Number Date Issued License Expiration Date

Has any disciplinary action EVER been taken against this license? YES NO

▶ If YES, please send certified copies of all disciplinary actions.

Is license now in good standing? YES NO

▶ If NO, please attach documentation.

(Board Seal)

Signature

Title

Board of Nursing / State

Date

NON-TRADITIONAL / REFRESHER PROGRAM INSTRUCTOR / PRECEPTOR AGREEMENT

All information requested in this form must be provided

Student Name (print legibly) _____

Colorado License Number _____

This Agreement, by and between the Student, Instructor/Preceptor, Faculty*, and Facility, is entered into for the purpose of providing clinical experience to Student pursuant to Colorado State Board of Nursing (“BON”) Rule 5.6, which is incorporated herein by reference. See www.dora.state.co.us/nursing/rules/rules.htm, and pursuant to section 3.4 of the Board’s *Chapter I – Rules and Regulations for the Licensure of Practical and Professional Nurses*. For good and valuable consideration, the parties, whose information is fully set forth below, agree as follows:

Instructor/Preceptor agrees to provide (circle one): **(A)** clinical supervision in a traditional format with one instructor directly overseeing a small group of students –OR– **(B)** direct supervision of student on a 1:1 basis. Instructor/Preceptor agrees to evaluate Student’s performance pursuant to the BON “Non-Traditional/Refresher Program Skills Checklist” and to provide Student with the required evaluation upon Student’s completion of the clinical portion of the refresher course. In addition, Instructor/Preceptor will provide official documentation and the original Non-Traditional/Refresher Program Skills Checklist in an official sealed envelope to student for submission to the BON;

- **NOTE: Instructor/Preceptor who signs this form must be the same instructor/preceptor who signs the Skills Checklist.**

Faculty* agrees that its refresher program will provide theoretical and didactic course work to the Student in official documentation as required by BON Rule 5.6;

Facility agrees that the clinical instruction required herein may be provided at its facility.

INSTRUCTIONS FOR COMPLETING THIS FORM: Applicants applying for PN reinstatement should have sections 1, 2 and 3 completed by your Instructor/Preceptor below:

1. Instructor/Preceptor: _____
Instructor/Preceptor signature _____ Date _____

Printed Name: _____

Title/Position: _____ Phone number: _____

License No(s): RN _____ PN _____ Status of License(s): _____

State(s) licensed: _____ Year(s) Issued: _____ Exp. date(s): _____

Educational degrees: _____ Yrs. clinical experience: _____

Schools attended & years graduated: _____

APPLICANT NAME: _____

2. Faculty: _____
Faculty member signature Date

Printed name of school: _____

Address of school: _____

Printed name of faculty member: _____

Title: _____ E-mail address: _____

Phone number: _____ Fax number: _____

3. Facility: _____
Facility representative signature Date

Printed name of facility: _____

Address of facility: _____

Facility provides (circle all that apply): acute care sub acute care skilled nursing

Printed name of facility representative: _____

Title: _____ E-mail address: _____

Phone number: _____ Fax number: _____

All Applicants must sign and date the form below:

4. Student: _____
Student signature Date

** Faculty: Individuals meeting the requirements of the rules, designated by the governing body as having ongoing responsibility for curriculum development, planning, teaching, guiding, monitoring, and evaluating student learning in the classroom and practice setting.*

**NON-TRADITIONAL / REFRESHER PROGRAM
Skills Checklist**

Student _____ Social Security Number _____

Program _____

Instructor/ Preceptor _____

Clinical Supervision Start Date _____ End Date _____

➤ **Please mark each competency as ‘Satisfactory’, ‘Needs Improvement’, OR ‘Not Observed’**

➤ **Note: All clinical competencies must be observed**

Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
PN Provider Role				
Performs services under the supervision of a registered nurse, physician, dentist or podiatrist.				
Performs and accurately collects basic health assessment data on patients contributing to the comprehensive patient assessment.				
Identifies common needs and problems, recognizes normal from abnormal findings and reports changes in findings to the appropriate health care professional.				
Contributes to the nursing plan of care.				
Provides basic care to those patients with predictable outcomes.				
Administers treatments, including medications as prescribed within the plan of care. Includes the medical plan of care and the nursing plan of care and: <ul style="list-style-type: none"> • Has accurate knowledge of the treatment procedure, and expected outcome. • Is skilled in safely administering the treatments. • Administers the right treatment to the right patient, at the right time. 				
Documents accurately and in a timely manner.				
Communicates to appropriate authority in a timely manner if patient refuses treatment, error is made, or an unpredicted event occurs.				
Uses technology, information and facility resources appropriately and effectively.				
Communicates in an accurate, clear and respectful manner with patients, families, supervisors and other Health Care Providers.				

Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
Develops and maintains appropriate relationships with patients, families, colleagues, and other health care professionals.				
Participates in the evaluation of patient outcomes and implementing necessary change.				
Assists in the formation of a teaching plan based on the needs of the patient.				
Supports and reinforces teaching as prescribed in the plan of care.				
Reports changes in individual / family / group condition in a timely manner and to the appropriate supervisor.				
PN Professional Role				
Is current in knowledge of illness care and treatment trends.				
Promotes patient safety.				
Is a safe practitioner that practices within the PN scope of practice				
Maintains patient confidentiality.				
Protects self and patients through safe practices such as universal precautions, lifting guidelines, and self-care practices.				
When directed coordinates, organizes and prioritizes care provided for the patient.				
• Assigns care appropriately.				
• Monitors care provided by assignees.				
• Offers feedback to assignees on care provided.				
• Uses effective communication and conflict management skills.				
• Promotes teamwork.				
Hours of Clinical Provided	Clinical hours Documented	Needs More Hours	Recommended Additional Hours	Preceptor Initials
120 hours required for applicants with license expired over 10 years with possible additional hours determined by Board				
120 hours required for applicants with license expired 6 and up to 10 years				
80 hours required for applicants with license expired 2-5 years				

***All clinical competencies must be observed. If competencies are marked “needs improvement,” or “not observed,” document on a separate sheet of paper the specifics of what you believe the applicant needs to be successful for each competency that is marked.**

NOTE: Instructor/Preceptor who signs this Skills Checklist and initials the “Preceptor Initials” column must be the same Instructor/Preceptor who signed the Non-Traditional/Refresher Program Preceptor Agreement.

APPLICANT NAME: _____

Attestation

I affirm that the clinical experience described on this form was conducted and completed in accordance with Colorado State Board of Nursing Rule 5.6 for Refresher Applicants. I further affirm that the clinical experience was completed under my supervision.

I declare under penalty of perjury in the second degree that the statements made herein are true and complete to the best of my knowledge.

Printed Name and Address of Instructor/Preceptor: _____

Daytime Contact Telephone Number of Instructor/Preceptor: _____

Colorado License Number: _____

Instructor/Preceptor Signature: _____ **Date Signed**

Student Signature: _____ **Date Signed**

Instructor/Preceptor should provide the original Skills Checklist in an official sealed envelope to the student for submission to the State Board of Nursing:

Division of Registrations
Office of Licensing—Nursing
1560 Broadway, Suite 1350
Denver, CO 80202