

APPLICATION FOR REGISTERED NURSE SPECIAL OR STUDENT PERMIT

APPLICANT INSTRUCTIONS

Basic Requirements. Requirements for receiving a Special or Student Permit to practice in the State of Colorado are outlined in the Colorado Revised Statutes, specifically 12-38-115, and Chapter I of the Board's rules. Documentation is available online at www.dora.state.co.us/nursing/index.htm.

The Board may issue a permit to practice as a professional nurse for a period not to exceed two (2) years (or as determined by the Board), to any person from another state or territory of the United States or a foreign country who is in this state for special training or for observation of nursing educational programs, under the following circumstances:

1. **Special Permits.** For occasional nursing practice which is **patient- or procedure-specific**.
 - ▶ You must hold an active and unrestricted license in another state or territory of the United States.
 - ▶ Nurses with established or regularly used healthcare agency connections in this state for the provision of such services will be required to possess a Colorado nursing license.
 - ▶ The nursing practice permitted by such permit shall be limited to that practice performed as part of the special training or nursing educational program.
 - ▶ Information about the practice must be documented in a letter from a healthcare agency, including the purpose of training with the beginning and ending dates.
 - ▶ **Note:** Nurses possessing an active, unencumbered, and unrestricted license in a state that is party to the nurse licensure compact pursuant to C.R.S. 24-80-3201 are not required to obtain a special practice permit for occasional nursing practice in Colorado.
2. **Student Permits.** For students of **non-traditional nursing education programs who must obtain in-state clinical training and experience.**
 - ▶ The nursing practice permitted shall be limited to that practice performed as part of the special training or nursing educational program.
 - ▶ The permits are only available for students who are seeking Colorado nursing licensure by examination.
 - ▶ The program is physically located in another state of the United States, or one of its territories.

Permits are not valid for permanent employment as a Registered Nurse. The permit is valid only to authorize the practice of nursing as outlined above and within the timeframe documented on the permit.

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 specified supporting documents must be submitted with the application. You may copy as many forms as needed; however, each form submitted must be completed in original ink or typed. Keep a copy of the completed application for your records.

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.

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.

APPLICANT CHECKLIST

To apply for either an RN Special Permit or an RN Student Permit:

- Submit a completed application and supporting documentation if required.** 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 the Affidavit of Eligibility form (attached).** 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).

If you are applying for an RN Special Permit:

- Submit a copy or screen print of a current Registered Nurse license in another state.**
 - Provide verification of original license.** Contact the state in which you received your original license by examination. Determine which type of verification is required and any required fees.
 - For NURSYS participating states, you must apply for NURSYS Verification at www.nursys.com. Visit the [NURSYS website](http://www.nursys.com) for a current list of participating states.
- OR**
- For NURSYS non-participating states, you must complete and submit a Request for Verification of Original Nursing License form (attached).
- Submit a letter from the agency or institution requiring your services.** The letter must include information about the purpose of the assignment, as well as beginning and ending dates of the assignment.

If you are applying for an RN Student Permit:

- Submit evidence of having completed an out-of-state nursing education program or other non-traditional nursing education program approved by the Colorado Board of Nursing.** Attach to your application an official transcript in its official sealed envelope indicating your completion of a nursing program. **NOTE: Failure to provide the transcript with your application could severely delay the processing of your application.**
- Enclose the completed Non-Traditional/Refresher Program Instructor/Preceptor Agreement (attached).** This agreement must be completed by the preceptor, the facility, and the student.
 - **Non-Traditional/Refresher Program Skills Checklist.** Once you have completed the course and received the completed Skills Checklist, you must submit an Application for Original License by Examination. The application is available on our website at www.dora.state.co.us/nursing. **Submit the original Non-Traditional/Refresher Program Skills Checklist – in its original sealed envelope – with that application.**

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 One: I am applying for a Registered Nurse **SPECIAL** Permit
 I am applying for a Registered Nurse **STUDENT** Permit

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 <input type="checkbox"/> Home <input type="checkbox"/> Business</i>	PO Box, Street: City, State, Zip:		
Daytime Telephone Number: ()		E-mail Address: <i>Preferred method for communication: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail</i>	

PART 2—LICENSE INFORMATION

State of first issue of RN license by examination:	Year license issued:				
List ALL states in which you are or have ever been licensed as a Registered Nurse, or other health care provider, including the nurse license information from the field above (if needed, attach an additional sheet in the same format). <u>If not applicable, enter N/A.</u>					
Type of license	State/Country	License Number	Year license Issued	Disciplinary action against license? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is this license current/active? <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
Have you ever been denied nursing or other healthcare licensure in Colorado or any other state?					<input type="checkbox"/> YES <input type="checkbox"/> NO
▶ If YES, attach a signed and dated explanation.					

*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	PERMIT NUMBER: _____	DATE ISSUED: _____	EXPIRES: _____
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PART 3—ASSIGNMENT INFORMATION (Complete for Special Permit only)

Name of agency/institution where the patient- or procedure-specific assignment will take place:

Agency Name: _____

Location: _____

Explain the purpose of the Special Permit you are requesting: _____

Assignment Dates From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

PART 4—SCREENING QUESTIONS

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

- On a separate sheet, provide 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? | <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 registered 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 registered 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 |

APPLICANT NAME: _____

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.

I understand that this permit only allows me to perform nursing care for the above-named assignment. I also attest that I have not established or regularly used healthcare agency connections in this state.

Applicant Signature

Date

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

For a list of Nursys participating states, please see 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 ORIGINAL NURSING LICENSE

You are responsible for ensuring your original 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 original state of 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	
Originally 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
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PART 2: To be completed by the LICENSING BOARD of original state of licensure and sent to the Colorado Office of Licensing.

	State Board Exam	NCLEX
Score		
Series/Form		

Original License/Registration Number	Date Issued	License Expiration Date
Has any disciplinary action EVER been taken against this license?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
▶ If YES, please send certified copies of all disciplinary actions.		
Is license now in good standing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
▶ If NO, please attach documentation.		

(Board Seal)	_____ Signature	_____ Title
	_____ State Board of Nursing	_____ Date

**NON-TRADITIONAL PROGRAM
INSTRUCTOR / PRECEPTOR AGREEMENT**

All information requested in this form must be provided.

Student name (print legibly) _____

This Agreement, by and between the Student, Instructor/Preceptor, and Facility, is entered into for the purpose of providing clinical experience to Student pursuant to Colorado State Board of Nursing ("BON") Policy 10-03, which is incorporated herein by reference. See www.dora.state.co.us/nursing/policies/policies.htm. 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 non-traditional/refresher course. In addition, Instructor/Preceptor will provide official transcripts and the Non-Traditional/Refresher Program Skills Checklist in a sealed envelope to Student for submission to BON;

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

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: _____

Facility: _____
Facility representative signature Date

Printed name of facility: _____

Address of facility: _____

Facility provides (circle all that apply): acute care subacute care

Printed name of facility representative: _____

Title: _____ E-mail address: _____

Phone number: _____ Fax number: _____

Student: _____
Student signature Date

This version of the Instructor / Preceptor Agreement may only be used in conjunction with RN Student Permit applications.

**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**

Bold Items are emphasized for graduates of Non-Traditional RN Programs

Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
RN Provider Role				
Performs a comprehensive patient assessment in order to establish a plan of care.				
Formulates a nursing plan of care with identified outcomes in collaboration with the patient, family and the health care team.				
Demonstrates use of a broad range of information, knowledge and skills; and critical thinking in the clinical decision-making processes when providing nursing care.				
Uses the nursing process, accepted practice standards, policies and procedures and established protocols when providing patient care.				
Delegates nursing functions appropriately. <ul style="list-style-type: none"> • Within the responsibility, knowledge, skill and ability of the RN delegating. • Routine, repetitive in nature and requires no nursing judgment or intervention. • Limited to a specific delegatee, for a specific client, and within a specific time frame except for delegation (exception is for K12 school nursing) 				

Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
Administers prescribed treatments including medications. <ul style="list-style-type: none"> • Has accurate knowledge of the treatment procedure, rationale for the treatment, and expected outcome. • Skilled in safely administering the treatment. • Checks for right patient, right treatment, and right time. • Documents accurately and communicates to appropriate authority in a timely manner if patient refuses treatment, error is made, or an unpredicted event occurs. 				
Includes the individual / family / group or other health care providers and assessment data in evaluating outcomes of care and revising the plan of care.				
Documents care provided and outcomes of care in an accurate and timely manner.				
Demonstrates appropriate and effective utilization of technology, analysis of information, and selection of resources in care implementation.				
Communicates in an accurate, clear and respectful manner with patients, families, supervisors and other health care providers.				
RN Teacher Role				
Formulates a teaching plan based on a nursing assessment and patient needs with consideration given to biological, psychological, social, spiritual, cultural, developmental, environmental and economic factors.				
Includes patient, family, and health care team in formulating the teaching plan.				
Utilizes critical thinking in making decisions on the design, content, and implementation of the teaching plan with the individual / family / group.				
Provides opportunities for individual, family, or group to demonstrate and receive feedback on the learning.				
Includes individual, family, group and health care team in the evaluation of learning outcomes as well as using established learning outcome indicators.				
Modifies the teaching-plan as indicated based on feedback from the evaluation and from health care team members.				
RN Manager Role				
Coordinates, organizes, prioritizes and modifies care provided for the individual / family / group or for multiple patients .				

Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
Demonstrates delegation or elaborates a realistic and safe plan based on the unit. <ul style="list-style-type: none"> • Assesses the needs, the knowledge and skills of health care personnel and own ability to supervise the personnel. • Instructs personnel in the task to be performed and the limits of the task and seeks agreement from the delegatee that he or she will perform the task. • Monitors the performance of the task to ensure it was completed properly. • Documents what and to whom the task was delegated and the expectations of the personnel in regard to the task and documentation. 				
Demonstrates supervision and assigning care or elaborates a realistic and safe plan based on the unit. <ul style="list-style-type: none"> • Assesses needs of the unit and personnel available. • Assigns care based on scope of practice. • Monitors and evaluates care provided to patients on the unit. 				
Evaluates and provides feedback to care providers responsible for providing care to patients under the RN's care.				
Uses critical thinking to problem solve and find solutions for managing care to groups of patients .				
Reviews and monitors therapy and treatment plans for effectiveness, accuracy, currency, and relevancy.				
Collaborates with interdisciplinary team members in organizing care for patients.				
Uses effective communication and conflict management skills.				
Effectively promotes teamwork among health care providers.				
RN Professional Role				
Is current in knowledge of illness care and treatment trends.				
Establishes collegial relationships with health care team and fellow RNs.				
Manages time and prioritizes activities to complete assignments.				
Is a safe practitioner that practices within his or her scope of practice as defined in the Nurse Practice Act.				
Supports and advocates for patient rights.				

Hours of Clinical Provided	Clinical Hours Documented	Needs More Hours	Recommended Additional Hours	Preceptor Initials
750 hours required for non-licensed practical nurse graduates of a non-traditional program				
350 hours required for licensed practical nurse applicant graduates from a non-traditional RN program				
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 checklist and initials the “Preceptor Initials” column, must be the same Instructor/Preceptor who signed the Non-Traditional/Refresher Program Preceptor Agreement.

I affirm that the clinical experience described on this form was conducted and completed in accordance with Colorado State Board of Nursing Policy 10-03 for Refresher Applicants and the *Chapter I Rules and Regulations for the Licensure of Practical and Professional Nurses* for graduates of Non-Traditional Education Program 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: _____

Contact Phone Number of Instructor/Preceptor _____ CO 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 student for submission to the State Board of Nursing

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