

**WEST VIRGINIA BOARD OF EXAMINERS FOR REGISTERED PROFESSIONAL NURSES
REINSTATEMENT APPLICATION**

101 Dee Drive, Suite 102, Charleston, WV 25311
304-558-3596 OR 1-877-743-6877 VOICE MAIL SYSTEM
Web: www.wvrnboard.com E-mail: rnboard@state.wv.us

Name _____ License Number (if known) _____

Address _____ SSN: _____
Street City State Zip

READ EACH QUESTION CAREFULLY: CIRCLE CORRECT RESPONSE

1. A. **REINSTATEMENT FEE = \$75.00 FROM LAPSED** _____ **\$25.00 FROM INACTIVE** _____
B. **Reinstatement with Name Change** = \$80.00 and requires a certified copy of the legal document changing your name or a signed and notarized affidavit. The affidavit is on the web site at www.wvrnboard.com
2. Marital Status: (S) - Single (M) - Married (W) - Widowed (D) - Divorced

YES* answers for 3 - 12 require additional information: an explanation and certified copies of court related documents

3. Have you ever been convicted of a felony? Yes* No
*send in certified copies of court documents
4. Have you ever been convicted of a misdemeanor, or plead nolo contendere or deferred prosecution or been pardoned in relation to any crime? (Any conviction exclusive of minor traffic violations such as speeding or parking violations must be reported. List speeding tickets only if you have received three (3) or more speeding tickets in the last three (3) years) Yes* No
5. Do you have any criminal charges currently pending in any state, territory or country? Yes* No
6. Has a complaint ever been filed against your RN license in West Virginia, or in any other state, territory or country? Yes* No
7. Has a complaint ever been filed against ANY license in this state or any other state, territory or country? Yes* No
8. Has disciplinary action ever been taken against ANY license in this state or any other state, territory or country? Yes* No
9. Has your nursing practice ever been monitored for any reason, disciplinary action or otherwise, by any facility, board or group? (Action includes monetary assessments or fines) Yes* No
10. Is there any reason why your access to narcotics or substances of abuse should be restricted or limited? Yes* No
11. Do you currently possess any condition which may affect your ability to safely and effectively engage in the practice of registered professional nursing? YES** Attach a letter of explanation. Yes** No
12. Do you have a court ordered child support obligation? Yes No
A. Does the amount of any unpaid obligation equal or exceed the amount of child support payable for six (6) months? Yes No
B. Are you currently the subject of a child-support or paternity subpoena? Yes No
13. Do you own all or part of a business that operates within West Virginia? Yes*** No
***If yes, please enter the FEIN number of your business _____

WV2-6(18) provides that a board may not issue or renew a license for you to engage in the practice of a profession if you are in default under either the unemployment or workers compensation laws, or both laws of the state.

14. I have _____, have not _____, been working as a registered professional nurse in the State of West Virginia since my license lapsed, or was placed on the inactive list.

15. Please circle all degrees held:
- | | |
|---------------------------------------|--|
| A. Diploma-Hospital School of Nursing | E. Masters in Nursing |
| B. Associate Degree | F. Masters in Other Field |
| C. Baccalaureate in Nursing | G. Nursing Doctorate: PhD, DNS, DNP |
| D. Baccalaureate in Other Field | H. Doctorate: Field _____ Degree _____ |
16. Are you currently employed?
- A. **YES, FULL TIME IN NURSING**
 B. **YES, PART TIME IN NURSING**
 C. **YES, other than nursing (circle one)** If YES, are you seeking employment in nursing? Yes _____ No _____
 D. **NO (circle one below)**
- | | | | |
|--------------------------|----------------------------------|---------------------|---------------------------|
| a. Retired | c. Salary Inadequate | e. No job available | g. Not seeking employment |
| b. Home Responsibilities | d. Seeking employment in nursing | f. Disabled | h. Other |

IF EMPLOYED PROVIDE THE FOLLOWING INFORMATION:

Employer: _____

Address _____ City _____ State _____ Zip _____

County of Employment: _____ State of Employment: _____

Number of hours Worked per week: _____ Number of weeks worked per year: _____

- FIELD OF EMPLOYMENT:**
- | | |
|-----------------------------------|------------------------------|
| A. HOSPITAL | H. SCHOOL/COLLEGE HEALTH |
| B. NURSING HOME/EXTD CARE | I. INDUSTRIAL/BUSINESS |
| C. SCHOOL OF NURSING | J. OFFICE |
| D. PRIV. PRACTICE/SELF EMPLOYED | K. TEMP. AGENCY/NURSING POOL |
| E. COMMUNITY/PUBLIC HEALTH AGENCY | L. MILITARY INSTALLATION |
| F. CLINIC/AMBULATORY CARE | M. OTHER: SPECIFY _____ |
| G. HOME HEALTH AGENCY | |

- TYPE OF POSITION:**
- | | |
|-------------------------|---------------------------------|
| A. ADMINISTRATOR/DON | G. SCHOOL NURSE |
| B. CONSULTANT | H. IN SERVICE/STAFF DEVELOPMENT |
| C. SUPERVISOR/ASSISTANT | I. QLTY. ASSURANCE/RISK MGNT |
| D. FACULTY/EDUCATOR | J. GENERAL DUTY/STAFF |
| E. RESEARCHER | K. OFFICE NURSE |
| F. HEAD NURSE/ASSISTANT | L. OTHER: SPECIFY _____ |

MAJOR CLINICAL TEACHING OR PRACTICE AREA:

- | | | |
|-----------------------------|--|-----------------|
| A. ANESTHESIA | I. MEDICAL SURGICAL | Q. OTHER: _____ |
| B. COMMUNITY/PUBLIC HEALTH | J. NEONATOLOGY | |
| C. EMERGENCY CARE | K. OBSTETRICS/GYNECOLOGY | |
| D. GENERAL PRACTICE | L. ONCOLOGY | |
| E. GERIATRIC | M. OPERATING/POST-ANESTHESIA RECOVERY | |
| F. HOME HEALTH | N. PEDIATRIC | |
| G. INTENSIVE /CRITICAL CARE | O. PSYCHIATRIC/MENTAL HLTH/SUBSTANCE ABUSE | |
| H. IV THERAPY | P. REHABILITATION | |

CERTIFICATION STATEMENT: By signing this application I hereby certify that the information provided on this application is complete and true. I understand that supplying false information is a violation of WV Code §30-7-1 et seq and subjects me to the full range of disciplinary action described therein. If I work or represent myself as an RN while my license is lapsed, I am subject to fines, administrative costs and disciplinary action, as defined in WV Code §30-7-1 et seq., and related laws and rules. I also certify that I have satisfactorily completed the required contact hours of continuing education (CE) prescribed in Legislative Rule §19CSR11 and WV Code §30-1-7a. By signing this application, I hereby certify that the information provided on this application is complete and true and that I have met one of the continuing education requirements below: 1) I was initially licensed in West Virginia before November 1, 2008 and have satisfactorily completed twelve (12) required contact hours of CE; or 2) I was initially licensed in West Virginia on or after November 1, 2008 and have satisfactorily completed twelve (12) required contact hours of CE that includes two (2) hours of CE in "End of Life Care Including Pain Management". There is a one time two (2) contact hour requirement for "End of Life Care Including Pain Management". If you completed a course in "End of Life Care Including Pain Management" at any time after you were initially licensed, you have met this requirement. Applications will be audited for compliance with continuing education. **Keep your CE certificates in a safe place so you may provide them if you are audited.**

Your Daytime Phone Number () _____ Home Phone Number: () _____

E-Mail Address: _____

LICENSEE SIGNATURE: _____ DATE: _____