



## FLORIDA BOARD OF NURSING

### **APPLICATION FOR TEMPORARY PRACTICE LETTER DURING DISASTER/EMERGENCY PRACTICE LETTER WILL EXPIRE AT THE TERMINATION OF EXECUTIVE ORDER 2010-06.**

**THIS APPLICATION IS FOR A TEMPORARY DISASTER/EMERGENCY PRACTICE LETTER ONLY. IF YOU WISH TO APPLY FOR FULL LICENSURE PLEASE APPLY USING THE ENDORSEMENT APPLICATION FOUND ON THE WEB AT [www.doh.state.fl.us/mqa/nursing](http://www.doh.state.fl.us/mqa/nursing)**

**This application must be submitted with:**

1. a cashier's check or money order made payable to the Department of Health for \$43.25
2. a copy of an active license, and
3. 2 fingerprint cards.

All sections must be completed in full. If an item does not apply, indicate with N/A. N/A is not an acceptable answer for "Yes" or "No" questions. Failure to submit a complete application will result in a processing delay. Applications can be mailed with the required fingerprint cards or faxed to (850) 617-6465. Applications cannot be approved until the fingerprint cards have been received; scanned and the results from the cards have been returned to the Board office.

**PERSONAL INFORMATION:** Applications will be processed in the complete name provided in this section. Be sure to use the same name and address on all documentation as it appears on the nursing license you are using to endorse and obtain a Florida nursing license.

**Physical Location:** Florida Sunshine Law requires that all licensees have a Physical Address/Practice Location on file with the Florida licensure Board. This location should be the physical/address location where you intend to work. If your mailing address is a P.O. Box you must provide another address. This address is required by law to be listed on the Department of Health website.

**APPLICANT BACKGROUND:** You must list all current and previous nursing licenses.

**HEALTH HISTORY:** Any applicant who answers "Yes" to any of the questions in this section will not qualify for this license.

**CRIMINAL HISTORY:** Any applicant who answers "Yes" to any of the questions in this section will not qualify for this license.

**DISCIPLINARY HISTORY:** Any applicant who answers "Yes" to any of the questions in this section will not qualify for this license.

**APPLICANT SIGNATURE:** The application must be signed by the applicant before submission. Failure to do so will result in a delay in processing of your application. Be sure the same name used on your application is on each document.

**Fingerprint Cards:** All applicants must complete two (2) fingerprint cards, per Florida Statutes 464.009(3). Failure to submit fingerprint cards will delay your application. Your local law enforcement agency will roll your fingerprints, and may charge you a fee. When you contact your local law enforcement agency, confirm that they have the FD-258 fingerprint cards. If the cards are unavailable, you may order blank fingerprint cards for a fee at [www.fldoh.sofn.net](http://www.fldoh.sofn.net).

All applicants are required to log on to the internet site: [www.fldoh.sofn.net](http://www.fldoh.sofn.net) to enter profile information. Print out the resulting barcode sheet, and mail it with your completed fingerprint cards to our office at:

Florida Board of Nursing, 4042 Bald Cypress Way, Suite 140 G, Tallahassee, FL 32399-7017

Entering your profile information is free and will ensure that your personal data is correctly entered. If you do not have access to the internet at home or work, you can use a computer at your local public library. Handle your fingerprint cards with the utmost care and mail them to our address in a flat envelope. Smudged, folded, or bent cards may result in rejected results making resubmission necessary.

**APPLICATION FOR TEMPORARY PRACTICE LETTER DURING DISASTER/EMERGENCY**

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK

**1. PERSONAL INFORMATION**

NAME: Last/Surname \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

DATE OF BIRTH (M/D/Y) \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

PHYSICAL LOCATION: \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_ WORK TELEPHONE: \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_ MOTHER'S MAIDEN NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER (U.S.) \_\_\_\_\_

**2. APPLICATION TYPE- YOU MUST HAVE A CURRENT ACTIVE LICENSE IN ANOTHER STATE TO QUALIFY FOR THIS TEMPORARY PRACTICE LETTER.**

Registered Nurse (RN)  Licensed Practical Nurse (LPN)

**3. APPLICANT BACKGROUND Attach additional sheets, if necessary**

State/Country License No. RN or LPN Date of Licensure If no longer licensed, state why & when

\_\_\_\_\_

Attach a copy or a current, active license from another state to this application.

**4. HEALTH HISTORY**

- A.  Yes  No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?
- B.  Yes  No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?
- C.  Yes  No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice nursing within the past five years?
- D.  Yes  No During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice nursing?
- E.  Yes  No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?
- F.  Yes  No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice nursing within the past five years?

**If you answered YES to any of the above questions, YOU ARE NOT ELIGIBLE FOR A TEMPORARY PRACTICE LETTER.**

**5. CRIMINAL HISTORY**

A.  Yes  No Have you **EVER** been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. **Driving under the influence (DUI) or driving while impaired (DWI) is not a minor traffic offense for purposes of this question.**

**Pursuant to Section 456.0635 (2), Florida Statutes, the following questions are being asked.**

1.  Yes  No Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396?

2.  Yes  No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

3.  Yes  No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program?

**If you answered YES to any of the above questions, YOU ARE NOT ELIGIBLE FOR A TEMPORARY PRACTICE LETTER.**

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**6. DISCIPLINARY HISTORY**

A.  Yes  No Have you ever been denied or is there now any proceeding to deny your application for any healthcare license to practice in Florida or any other state, jurisdiction or country?

B.  Yes  No Have you ever had disciplinary action taken against your license to practice any healthcare related profession by the licensing authority in Florida or in any other state, jurisdiction or country?

C.  Yes  No Have you ever surrendered a license to practice any healthcare related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?

D.  Yes  No Do you have any disciplinary action pending against your license?

**If you answered YES to any of the above questions, YOU ARE NOT ELIGIBLE FOR A TEMPORARY PRACTICE LETTER.**

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**7. APPLICANT SIGNATURE**

I, the undersigned, state that I am the person referred to in this application for practice letter in the State of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083 and 775.084, Florida Statutes.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application I hereby agree that such act shall constitute cause for denial, suspension or revocation of my practice letter allowing me to practice as a Registered Nurse or Licensed Practical Nurse in the State of Florida.

I further state that I have read and understand Chapter 464, Florida Statutes, and Rule 64B9, Florida Administrative Code as they pertain to the practice of nursing (Note: A current copy of Ch 464 and Rule 64B9 may be obtained via the internet at <http://www.doh.state.fl.us/mqa/nursing>).

Florida Law requires you to immediately inform the Board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I affirm that I will comply with all requirements for the issuance of my practice letter including written request for extension should the Governor's Executive Order 10-20 be extended allowing additional practice time.

**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_