



ADVANCED PRACTICE REGISTERED NURSE LICENSE REACTIVATION AND REINSTATEMENT APPLICATION

APRN Name
Address
City, State, Zip

Reactivation/Reinstatement Application

APRNs are not considered reactivated/reinstated until the application and fee (if applicable) are received and processed by the Board. You cannot reactivate/reinstate your APRN license without a current, valid RN license. Please complete and email this application to “aprn@nursing.ohio.gov”.

Non- Refundable Fee

A fee (if applicable) will be processed electronically. You will be contacted for further instructions. Fees are non-refundable.

National Certification

APRNs must meet all requirements of the Board including maintaining national certification or recertification by the applicable national certifying organization. Please refer to the website for Board approved national certifying organizations. The Board requires primary source verification for APRN national recertification. For this to occur, you must request that your national certifying organization notify the Board directly within thirty days of your recertification. The Board will not accept documentation of recertification from an APRN.

Social Security Number

Your social security number is required by state and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the National Practitioner Data Bank (Public Law 100-93, Sec. 1921 of the Social Security Act, as amended; 45 C.F.R. pt. 60); reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

Continuing Education (CE)

For a Certified Nurse Midwife (CNM), Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist, (CRNA), and Clinical Nurse Specialist (CNS), national certification must be maintained for your APRN License. A CNS who is not certified by a national certifying organization must obtain an additional twelve (12) contact hours of CE in their area of practice. Additionally, twelve (12) contact hours of CE in advanced pharmacology, which includes instruction specific to controlled substances, is required if you held APRN license for full renewal period. If the APRN license was held less than a full renewal period, only six (6) contact hours of CE is required. You must submit documentation of CE in order to reactivate/reinstate your APRN license.

Important Information

- Your APRN license will not be reactivated/reinstated until a completed application and fee are received and processed by the Board.
- Your application is considered incomplete if all sections have not been completed, you have not signed your application, your fee is incorrect, or you have not submitted the required CE documentation.
- You cannot practice and prescribe as an APRN without a current, valid RN and APRN license.

PPLYING TO REACTIVATE/REINSTATE (check all that apply):	
Certified Nurse Midwife (APRN.CNM)	<input type="checkbox"/> I have maintained national certification as a CNM.
Certified Nurse Practitioner (APRN.CNP)	<input type="checkbox"/> I have maintained national certification as a CNP.
Certified Registered Nurse Anesthetist (APRN.CRNA)	<input type="checkbox"/> I have maintained national certification as a CRNA.
Clinical Nurse Specialist (APRN.CNS)	<input type="checkbox"/> I have maintained national certification as a CNS or <input type="checkbox"/> I meet CE requirements for a CNS without national certification.

COMPLIANCE: Answer Yes or No to each question.

The following questions apply **SINCE** the submission of your last renewal application **OR** if this is your first renewal from the date your original license application was filed. Have you been convicted of, found guilty of, pled guilty to, pled no contest to, pled not guilty by reason of insanity to, entered an Alford plea, received treatment or intervention in lieu of conviction, or been found eligible for pretrial diversion or a similar program for any of the following crimes? This includes crimes that have been expunged if the crime has a direct and substantial relationship to nursing practice.

Yes		No	
1a	<input type="checkbox"/>	<input type="checkbox"/>	A felony in Ohio, another state, commonwealth, territory, province, or country? If "Yes", was the felony any of the following: aggravated murder, murder, voluntary manslaughter, felonious assault, kidnapping, rape, sexual battery, gross sexual imposition, aggravated arson, aggravated robbery, or aggravated burglary? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the felony a drug offense? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer "Yes", enter the court and case number. Court Name: _____ Case#: _____
1b	<input type="checkbox"/>	<input type="checkbox"/>	A misdemeanor in Ohio, another state, commonwealth, territory, province, or country? This does not include traffic violations unless they are DUI/OVI or Physical Control While Under the Influence. If you answer "Yes", enter the court and case number. Court Name: _____ Case#: _____
2.	<input type="checkbox"/>	<input type="checkbox"/>	Has any board, bureau, department, agency or other body, including those in Ohio, other than this Board , in any way limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you; placed you on probation, or imposed a fine, censure, or reprimand against you? Have you voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate, or registration?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Have you for any reason, been denied an application, issuance, or renewal for licensure, certification, registration, or the privilege of taking an examination, in any state (including Ohio), commonwealth, territory, province, or country?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Have you entered into an agreement of any kind, whether oral or written, with respect to a professional license, certificate, or registration in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio, other than this Board ?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been notified of any current investigation of you, or have you been notified of any formal charges, allegations, or complaints filed against you by any board, bureau, department, agency, or other body, including those in Ohio, other than this Board , with respect to a professional license, certificate, or registration?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been found to be a mentally ill person subject to hospitalization by court order, been found to be mentally incompetent by a probate court, or been found incompetent to stand trial by a court?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Are you required to register, under Ohio law, the law of another state, the U.S., or a foreign country, as a sex offender?
8.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been addicted to, dependent on, diagnosed with addiction, dependence or substance abuse disorder related to, or treated for addiction, abuse, dependence or substance disorder related to your use of alcohol or any chemical substance; or have you used any drugs that are illegal or were prescription drugs used by you without a legal, valid prescription?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio ?
10.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked?

If you answer "Yes" to questions 1, 6, or 7, you are required to provide the Board with a written explanation of the events including the date, county, and state in which the events occurred, a certified copy of the indictment or criminal complaint, plea, or journal entry from the appropriate court(s). A copy of the court docket or case summary does not meet this requirement. If you answer "Yes" to questions 2, 3, 4, 5, or 8, you are required to provide the Board with a written explanation and certified copies of any documents (if applicable).

Social Security Number (Changes only):

Old: _____

New: _____

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VERIFICATION:

I am a U.S. citizen or lawfully admitted into the U.S. or I am a foreign national not living in the United States. I verify that all information on this form is true and accurate. I am aware that misrepresentation on this application may result in disciplinary action in accordance with Section 4723.28, ORC.

SIGNATURE: _____



Supplemental Information for Reinstatement/Reactivation

Applying to reinstate/reactivate (check all that apply):

- APRN.CNM
APRN.CNP

- APRN.CNS
APRN.CRNA

License# Date of Birth

Name (Last) (First) (Middle)

Telephone# Email

Table with 3 columns: Question, Yes, No. Question: Have you practiced in Ohio since your license was inactive or lapsed?

If the answer to the above question is NO, do not answer the questions below. Just sign and date the bottom of the form.

Table with 3 columns: Question, Yes, No. Questions include: Did this position require an active Ohio license? Did you directly or indirectly supervise the practice of nursing? Did you delegate nursing tasks to an unlicensed person? Did you issue any prescriptions? Did you use any of the following title/initials LPN, RN, APRN.CNM, APRN.CNP, APRN.CNS, APRN.CRNA while your license was inactive or lapsed?

Ohio Employer/Facility Dates of Employment
Supervisor or Collaborating Physician/Podiatrist
Address City
State Zip Code Telephone#
Title and Description of Duties (use additional pages as needed)

I CERTIFY THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND ACCURATE

Signature Date