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Contents

Ways to Reach Us ................................................................................................................................. ii
Applying for a Certificate as a Nurse Practitioner .............................................................................. 1
Nurse Practitioner Summary of Requirements "At a Glance" ............................................................. 11
Completing the Application Forms ..................................................................................................... 13
Applicant Checklist ............................................................................................................................ 15

Forms

FORM 1 - Application for a Certificate
FORM 2 - Certification of Professional Education
FORM 2B - Verification of Instruction in New York State and Federal Laws Related to Prescriptions and Record Keeping
FORM 2C - Verification of Pharmacotherapeutics Course
FORM 3 - Verification of National Nurse Practitioner Examination
FORM 4 - Verification of Experience
FORM 4NP - Verification of Collaborative Agreement and Practice Protocol

Additional Forms

FORM AD/NAME - Address/Name Change Form

FOR FUTURE REFERENCE

IN THE EVENT OF AN EMERGENCY that impacts the licensed professions, the Office of the Professions will provide important information, specific to the situation, through our Web site (www.op.nysed.gov), our automated phone system (518-474-3817), and/or our regional offices. This information will include emergency provisions for professional practice as well as updates on scheduled events and services (licensing examinations, professional discipline proceedings, examination reviews, etc.).
Ways to reach us...

⇔ General Customer Service

The Office of the Professions has an automated customer service system that allows callers to verify licenses, request information, and hear automated messages 24 hours a day. The number is 518-474-3817, TDD/TTY 518-473-1426. Staff are available from 8:30 a.m. to 4:45 p.m., Eastern Time, Monday through Friday. You may also fax a message to 518-474-1449 or e-mail us at op4info@mail.nysed.gov.

⇔ On The World Wide Web

Information about the Office of the Professions and the 47 licensed professions, including information on all licensees, is available on our home page at:

www.op.nysed.gov

⇔ Certificate Application Status

Find out the status of your certificate application by checking our Web site where your name is added immediately when a certificate is issued, or contact:

New York State Education Department, Office of the Professions, Division of Professional Licensing Services
Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000
PHONE: 518-474-3817 ext. 270, FAX: 518-402-5354, E-MAIL: opunit3@mail.nysed.gov
Please include your name, social security number, date of birth, and the name of the profession.

⇔ Verification of Education Credentials From Foreign or Non-Approved Programs

If you have questions about documentation required to verify education completed outside the U.S. or in non-approved programs, contact:

New York State Education Department, Office of the Professions, Bureau of Comparative Education
89 Washington Avenue, Albany, New York 12234-1000
PHONE: 518-474-3817 ext. 300, FAX: 518-486-2966, E-MAIL: comped@mail.nysed.gov

⇔ Practice Issues

For answers to questions concerning practice issues, contact:

NYS Education Department, Office of the Professions, State Board for Nursing
89 Washington Avenue, Albany, NY 12234-1000
PHONE: 518-474-3817 ext. 120, FAX: 518-474-3706, E-MAIL: nursebd@mail.nysed.gov
APPLYING FOR A CERTIFICATE AS A NURSE PRACTITIONER

GENERAL REQUIREMENTS

Use of the title "Nurse Practitioner" within New York requires a certificate issued by the New York State Education Department.

To receive a certificate to practice as a nurse practitioner in New York State you must:

• have a currently registered New York State license as a Registered Professional Nurse (RN); and
• meet education requirements.

A nurse practitioner is authorized to practice in a specific specialty area. You may be authorized in more than one specialty. Current specialty areas are: Acute Care, Adult Health, College Health, Community Health, Family Health, Gerontology, Holistic Care, Neonatology, Obstetrics/Gynecology, Oncology, Pediatrics, Palliative Care, Perinatology, Psychiatry, School Health, Women's Health.

You must file an Application for a Certificate (Form 1) for each specialty area you want to be authorized in and all other forms indicated to demonstrate that you have satisfied the education requirements specific to that specialty area, along with the appropriate fee, to the Office of the Professions at the address specified on each form. It is your responsibility to follow up with anyone you have asked to send us material. Once authorized, you must maintain the registration of your RN license and your NP certificate in order to practice as a nurse practitioner.

The specific requirements to obtain a certificate are contained in Title 8, Article 139, Section 6910 of New York's Education Law and Part 64 of the Commissioner's Regulations. For additional information regarding legal requirements for licensed/certified professionals, see the section on "Professional Conduct."

FEES (fees listed are those in effect at the time this application was printed)

The fee for a certificate in each nurse practitioner specialty area is $85. ($50 certificate application fee plus a $35 fee for initial registration.)

Fees are subject to change. The fee due is the one in law when your application is received (unless fees are increased retroactively). You will be billed for the difference if fees have been increased.

• Do not send cash.
• Make your personal check or money order payable to the New York State Education Department. Your cancelled check is your receipt.
• Mail your application and fee to: NYS Education Department, Office of the Professions at the address at the end of the Application for a Certificate (Form 1).

PLEASE NOTE: Payment submitted from outside the United States should be made by check or draft on a United States bank and in United States currency; payments submitted in any other form will not be accepted and will be returned.

PARTIAL REFUNDS

Individuals who withdraw their application for a certificate any time prior to a determination may be entitled to a partial refund.

• For the procedure to withdraw your application, contact the Nurse Practitioner Unit by e-mailing opunit3@mail.nysed.gov or by calling 518-474-3817 ext. 270 or by faxing 518-402-5354.
• The State Education Department is not responsible for any fees paid to an outside testing or credentials verification agency.
If you withdraw your application, obtain a refund, and then decide to seek a New York State certificate at a later date, you will be considered a new applicant, and you will be required to pay the application fee and meet the requirements for a certificate that are in place at the time you reapply.

ADDRESS OR NAME CHANGES

If your mailing address or name changes, you must contact the Department to update your records and provide the following identifying information: your full name, social security number, profession and date of birth. Failure to provide the Department with your change of address or name will delay processing your application.

For address changes you may phone, fax or e-mail:

Phone: 518-474-3817 ext. 270
TDD/TTY 518-473-1426

Fax: 518-402-5354

E-mail: opunit3@mail.nysed.gov

For name changes a fax or e-mail is not acceptable. You must provide written notification of any name change with an original notarized signature in your new name to:

NYS Education Department, Office of the Professions
Division of Professional Licensing Services
Nurse Practitioner Unit
89 Washington Avenue
Albany, NY 12234-1000

NOTE: Once you have obtained a certificate, Education Law requires that you notify the Department of any change in your mailing address or name within 30 days of that change. Failure to do so may be considered professional misconduct. It may also delay renewal and result in late fees to renew. You may use the Form AD/NAME located in the back of this packet or print a copy from our Web site at www.op.nysed.gov/anchange.pdf to notify the Department of a change in your address or name.

PROFESSIONAL CONDUCT

All licensed/certified practitioners must adhere to rules of professional conduct. The Education Law includes definitions of professional misconduct, and the Board of Regents has adopted Rules defining unprofessional conduct for all professions. Every licensee is also governed by a set of Laws, Rules, and Regulations for the practice of the profession.

Title 8 of the NYS Education Law is available on our Web site at www.op.nysed.gov/title8.htm

Part 29 of the Rules of the Board of Regents is available on our Web site at www.op.nysed.gov/part29.htm
To satisfy the education requirements for a certificate as a nurse practitioner, you must present evidence of satisfying the requirements of A or B or C below. Additionally, you must meet the requirements for D below.

A. Completion of a nurse practitioner education program registered by the New York State Education Department as qualifying for a certificate, or a program determined by the Department to be equivalent to a registered program, which is designed and conducted to prepare graduates to practice as nurse practitioners.

B. Certification as a nurse practitioner by one of the following national certifying organizations:

- American Academy of Nurse Practitioners
  P.O. Box 12846
  Austin, TX 78711
  Phone: 512-442-4262
  Web: www.aanp.org

- American Holistic Nurses Certification Corporation
  811 Linden Loop
  Cedar Park, Tx. 78610
  Phone: 512-528-9210
  E-mail: AHNCC@Flash.net

- National Certification Corporation
  (Formerly NAACOG)
  P.O. Box 11082
  Chicago, IL 60611-0082
  Phone: 312-951-0207
  Web: www.nccnet.org

- American Nurses Credentialing Center
  Attn: Verification Specialist
  P.O. Box 791321
  Baltimore, MD 21279-1321
  Web: http://nursingworld.org/ancc/

- National Board for Certification of Hospice and Palliative Nurses
  One Penn Center West
  Pittsburgh, Pa 15276-0100
  Phone: 412-787-1057
  E-mail: nbchpn@hpna.org

C. Satisfaction of alternative requirements for a certificate for graduates of nurse practitioner programs prior to April 1, 1989, as follows:

- completion of at least a four-week long (full-time) nurse practitioner program prior to April 1, 1989;

  and either

- two years of experience prior to April 1, 1989, of which one year must be after April 1, 1986, in the provision of primary health care services in a health care facility licensed pursuant to Article 28 of the Public Health Law or in a school health demonstration project;

  or

- completion of a supplemental educational program culminating in the successful completion of a comprehensive examination or clinical evaluation.

AND
D. **Satisfaction of the pharmacotherapeutic requirement** (for all applicants, regardless of whether A, B, or C above was completed). You must document:

- completion of not less than three semester hours, or the equivalent, in pharmacotherapeutics to include instruction in drug management of clients in the nurse practitioner specialty area and instruction in New York State and Federal laws and regulations relating to prescriptions and record keeping;

  or

- completion of an educational program or a combination of courses which is the substantial equivalent in content and scope to the pharmacotherapeutics course listed above;

  or

- satisfactory completion of an examination in pharmacotherapeutics acceptable to the Department;

  or

- satisfactory completion of a nationally recognized examination acceptable for licensure in New York State as a physician assistant or for certification as a nurse midwife.

**Please Note:** If you have completed a program other than one that is registered by New York State as qualifying for a nurse practitioner certificate and/or your pharmacotherapeutics course did not include instruction in New York State and Federal laws and regulations related to prescriptions and record keeping, you may contact the following professional associations for required instruction:

The Nurse Practitioner Association of New York State
12 Corporate Drive
Clifton Park, New York 12065
Phone: 518-348-0719
Web: www.thenpa.org

The New York State Nurses Association
11 Cornell Road
Latham, NY 12110-1499
Phone: 518-782-9400 ext. 278
Web: www.nysna.org

**PRESCRIPTION FORMS**

If you satisfy all requirements for a certificate as a nurse practitioner, you will be authorized to issue prescriptions pursuant to Section 6902 (3) (b) of the Education Law.

**New York State Prescription Forms** may be obtained from:

New York State Department of Health
Bureau of Narcotic Enforcement
433 River Street, Suite 303
Troy, NY 12180
Phone: 866-811-7957 or 518-402-0708

**National Provider Identifier (NPI)**

All health care providers - including those serving Medicare beneficiaries - are now required to apply for a new National Provider Identifier (NPI) that will be used in all electronic health care transactions. The NPI will replace all other provider identifiers currently being used. The National Provider Identifier initiative was mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and requires that NPIs be used by health plans, health care clearinghouses, and health care providers that process
claims, handle claim status inquiries/responses and eligibility inquiries/responses, as well as other transactions. Nurse practitioners can apply for an NPI by going to http://nppes.cms.hhs.gov. Applications can be submitted online or via regular mail.

**Federal Drug Enforcement Administration Number (DEA)**

A Federal Drug Enforcement Administration (DEA) Number is required to prescribe and dispense narcotic and controlled substances. A DEA number may be obtained from:

United States Department of Justice
Drug Enforcement Administration
99 10th Avenue
New York, NY 10011
Phone: 877-883-5789, 800-882-9539 or 212-337-1593
Fax: 212-337-2867 or 2895
Web: www.deadiversion.usdoj.gov

**COLLABORATIVE AGREEMENTS AND PROTOCOL TEXT**

**Collaborative Agreement**

You are required to establish a collaborative agreement with one physician prior to beginning practice and maintain that agreement in the practice setting(s) where it will be available for inspection by the State Education Department (SED). New practitioners are also required to submit Form 4NP-Verification of Collaborative Agreement and Practice Protocol only once to the SED’s Office of the Professions no later than 90 days after beginning professional practice.

The collaborative agreement shall include provisions for referral and consultation, coverage for absences of either the nurse practitioner or the collaborating physician, resolution of disagreements between the nurse practitioner and the collaborating physician regarding matters of diagnosis and treatment, the review of a representative sample of patient records every three months by the collaborating physician, record keeping provisions and any other provisions jointly determined by the nurse practitioner and the physician to be appropriate. A sample collaborative agreement is included for your convenience.

**Protocol Text as Practice Protocol**

You are also required to identify a protocol text, from the approved list on pages 8-10, as your official practice protocol which must reflect the specialty area of practice as identified on your State Education Department issued nurse practitioner certificate. The approved protocol texts include provisions for case management, diagnosis and treatment of pathology in the specialty area. Additional protocols or textbooks which may be appropriate to the practice and/or employment setting may be used but need not be reflected in the collaborative agreement.

Questions about collaborative agreements and practice protocols may be referred to the State Board for Nursing by e-mailing nursebd@mail.nysed.gov or by calling 518-474-3817 ext. 120, or by faxing 518-474-3706.
(Sample) Collaborative Practice Agreement

This agreement sets forth the terms of the Collaborative Practice Agreement between (nurse practitioner and specialty as listed on the State issued certificate) and (name of collaborating physician and specialty if any) at (name and address of agency or entity where practice takes place). This agreement shall take effect as of (date).

Introduction

(YOUR NAME RN, NP) meets the qualifications and practice requirements as stated in Chapter 257 of the Laws of 1988 and Article 139 of the Education Law of New York State, holds a New York State license and is currently registered as a registered professional nurse in good standing, holds a certificate as a nurse practitioner pursuant to Sec. 6910 of the Education law and herein meets the requirement of maintaining a collaborative practice agreement with (NAME OF COLLABORATOR, MD/DO) a duly licensed and currently registered physician in good standing under Article 131 of the New York State Education Law.

I. Scope of Practice

The practice of a registered professional nurse as a nurse practitioner may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures including prescribing medications for patients whose conditions fall within the authorized scope of the practice as identified on the college certificate. This privilege includes the prescribing of all controlled substances under a DEA number. The nurse practitioner, as a registered nurse, may also diagnose and treat human responses to actual or potential health problems through such services as case finding, health counseling, health teaching, and provision of care supportive to or restorative of life and well-being. This practice will take place at (above identified agency) or in such other facility or location as designated by (name of identified agency) or by the parties of this contract. The following exceptions to the certified scope of practice have been agreed upon by the undersigned parties: (list exception(s)).

II. Practice Protocols

The protocols used in this (identify specialty as listed on State issued certificate) practice are contained in (name approved protocol text with all bibliography citations) and in (cite location of any other protocols which are germane to this particular practice).

III. Physician Consultation

The parties shall be available to each other for consultation either on site or by electronic access including but not limited to telephone, facsimile and email. Each party will cover for the other in the absence of one of them or (names of third parties) who are designated by (YOUR NAME, RN, NP and NAME OF COLLABORATOR MD/DO) as appropriate for coverage in the absence of both parties. In the event that there is an unforeseen lack of coverage, patients will be referred to the appropriate emergency room.

IV. Record Review

A representative sample of patient records shall be reviewed by the collaborating physician every three months to evaluate that (name of NP)'s practice is congruent with the above identified practice protocol documents and texts. Summarized results of this review will be signed by both parties and shall be maintained in the nurse practitioner's practice site for possible regulatory agency review. Consent forms for such review will be obtained from any patient whose primary physician is other than (name of collaborating physician).
V. Resolution of Disagreements

Disagreement between (name of nurse practitioner) and (name of collaborating physician) regarding a patient's health management that falls within the scope of practice of both parties will be resolved by a consensus agreement in accordance with current medical and nursing peer literature consultation. In case of disagreements that cannot be resolved in this manner, (name of collaborative physician's) opinion will prevail. In disagreements between the nurse practitioner and non-collaborating physicians, the collaborating physician’s opinion will prevail.

VI. Alteration of Agreement

The collaborative practice agreement shall be reviewed at least annually and may be amended in writing in a document signed by both parties and attached to the collaborative practice agreement.

VII. Agreement

Having read and understood the full contents of this document, the parties hereto agree to be bound by its terms.

Nurse Practitioner (Specialty):

Printed Name______________________________ RN license #________________

Certificate #______________________________

Signature____________________________________ Date_______________________

Collaborating Physician:

Printed Name______________________________ MD license #________________

Board Certification____________________________________________________

Signature__________________________________________ Date_______________________
APPROVED PROTOCOL TEXTS
(Please note: more recently published editions of the same text title are acceptable)


Revised: July 2008
# NURSE PRACTITIONER SUMMARY OF REQUIREMENTS “AT A GLANCE”

*(See Completing the Application Forms on page 13)*

<table>
<thead>
<tr>
<th>If you are....</th>
<th>Submit to: New York State Education Department, Office of the Professions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Form 1 and Fee</td>
</tr>
<tr>
<td>A graduate of a New York State registered, certificate-qualifying program, submit…</td>
<td>✓</td>
</tr>
<tr>
<td>A graduate of a program other than a New York State registered, certificate-qualifying program, submit…</td>
<td>✓</td>
</tr>
<tr>
<td>Certified as a nurse practitioner from an approved professional organization, submit…</td>
<td>✓</td>
</tr>
<tr>
<td>An applicant who completed alternative certificate requirements prior to 1989, submit…</td>
<td>✓</td>
</tr>
</tbody>
</table>

*Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is required only _once._*
INSTRUCTIONS

Please type or print all information and sign all forms in black or blue ink. Original signatures are required on all forms.

FORM 1 - APPLICATION FOR A CERTIFICATE

All applicants for a certificate must complete this form and submit it with the $85 fee for a certificate and initial registration directly to the Office of the Professions at the address at the end of Form 1. Make checks payable to the New York State Education Department. NOTE: Your cancelled check is your receipt.

You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. Your signature on Form 1 must be notarized by a Notary Public.

FORM 2 - CERTIFICATION OF PROFESSIONAL EDUCATION (For applicants who have completed a program registered by the State Education Department as qualifying for a certificate or a program determined by the Department to be equivalent; see pages 3-4.)

This form must be submitted directly to the Office of the Professions by the professional school you attended. This form will not be accepted if submitted by the applicant or any party other than the school official.

Section I: Complete this section of the form before sending the entire form to your school. Be sure to sign and date item 11.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

FORM 2B - VERIFICATION OF INSTRUCTION IN NEW YORK STATE AND FEDERAL LAWS RELATED TO PRESCRIPTIONS AND RECORD KEEPING (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

This form must be submitted directly to the Office of the Professions by the school, institution or professional association where you completed instruction. This form will not be accepted if submitted by the applicant or any party other than the school, institution or professional association official.

Section I: Complete this section of the form before sending the entire form to the school, institution or professional association where you completed instruction in New York State and federal laws relating to prescriptions and record keeping. Be sure to sign and date item 8.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

FORM 2C - VERIFICATION OF PHARMACOTHERAPEUTICS COURSE (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

This form must be submitted directly to the Office of the Professions by the school, institution or professional association where you completed instruction. This form will not be accepted if
submitted by the applicant or any party other than the school, institution or professional association official.

Section I: Complete this section before sending the entire form to the school institution or professional association where you completed a pharmacotherapeutic course, including instruction in drug management of clients in the nurse practitioner’s specialty area. Be sure to sign and date item 8.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

FORM 3 - VERIFICATION OF NATIONAL NURSE PRACTITIONER EXAMINATION (For applicants seeking a New York State nurse practitioner certificate through a national certifying organization.)

This form must be submitted directly to the Office of the Professions from the national certifying organization that will verify your certification examination. The Office of the Professions will not accept this form if submitted by the applicant or any other party.

Section I: Complete this section before sending the entire form to the national certifying organization to verify that you passed the nurse practitioner certification examination. Be sure to sign and date item 9.

Section II: The national certifying organization must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

FORM 4 - VERIFICATION OF EXPERIENCE (For applicants following pre-1989 alternative requirements for a certificate.)

This form is required within 90 days after commencement of practice.

Section I: Complete this section of the form before sending the entire form to the physician who supervised your experience within the specialty for which you are seeking a certificate. Be sure to sign and date item 7.

Section II: The supervising physician must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

A separate Form 4 must be submitted by each physician with whom you worked with while acquiring the required experience.

FORM 4NP - VERIFICATION OF COLLABORATIVE AGREEMENT AND PRACTICE PROTOCOL (All applicants.)

Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is only required once.

Section I: Complete this section of the form.

Section II & III: You and the initial collaborating physician with whom you have a practice agreement and practice protocol must complete these sections and return both pages of the form to the Office of the Professions at the address at the end of the form. Be sure to sign item 4 in Section III.

Completing Additional Forms

FORM AD/NAME - ADDRESS/NAME CHANGE FORM

You are required to notify us within 30 days of any name or address changes. Please read the instructions and complete the appropriate sections of this form.
NURSE PRACTITIONER

APPLICANT CHECKLIST

Please complete and keep this checklist as a reminder of what forms you have filed and when you filed them. This is for your reference and should not be submitted with your application forms. You should keep a copy of all application forms submitted.

CHECK (✓) AND DATE EACH STEP WHEN COMPLETED.

______ 1. Have you completed and sent the following to the Office of the Professions?

______ A. FORM 1 - APPLICATION FOR A CERTIFICATE

______ B. FEE ($85) - FOR A CERTIFICATE AND INITIAL REGISTRATION

______ 2. Have you completed and forwarded the following forms to the appropriate institution(s) or agencies?

Keep copies of the requests so that you may check with them to be sure they have submitted the information.

______ A. FORM 2 - CERTIFICATION OF PROFESSIONAL EDUCATION (For applicants who have completed a program registered by the State Education Department as qualifying for a certificate or a program determined by the Department to be equivalent; see pages 3-4.)

Sent to the following educational institutions: Date sent

________________________________________________________

________________________________________________________

________________________________________________________

______ B. FORM 2B - VERIFICATION OF INSTRUCTION IN NEW YORK STATE AND FEDERAL LAWS RELATED TO PRESCRIPTIONS AND RECORD KEEPING (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

Sent to the following school/institution/professional association: Date sent

________________________________________________________

________________________________________________________

________________________________________________________

______ C. FORM 2C - VERIFICATION OF PHARMACOTHERAPEUTICS COURSE (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

Sent to the following school/institution/professional association: Date sent

________________________________________________________

________________________________________________________

________________________________________________________
D. FORM 3 - VERIFICATION OF NATIONAL NURSE PRACTITIONER EXAMINATION (For applicants seeking a New York State nurse practitioner certificate through a national certifying organization.)

Sent to the following national certifying organization: Date sent

________________________________________________________ __________________
________________________________________________________ __________________

E. FORM 4 - VERIFICATION OF EXPERIENCE (For applicants following pre-1989 alternative requirements for a certificate.) This form is required within 90 days after commencement of practice.

Sent to the following supervising physician(s): Date sent

________________________________________________________ __________________
________________________________________________________ __________________

F. FORM 4NP - VERIFICATION OF COLLABORATIVE AGREEMENT AND PRACTICE PROTOCOL (all applicants) This form is required within 90 days after commencement of initial practice.

TO SPEED PROCESSING OF YOUR APPLICATION:

• Submit your application for a New York State certificate in plenty of time to allow verifying organizations to send the required independent verifications to the Office of the Professions. This may take eight weeks or more.
• Notify the Office of the Professions promptly of any address or name changes.
• Respond promptly to requests for additional information from the Office of the Professions.
Application for a Certificate
Applicants Must Complete All Pages of This Application In Ink

All applicants for a certificate must complete this form and submit it with the $85 fee for a certificate and initial registration directly to the Office of the Professions at the address at the end of this form. You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. Form 1 must be notarized by a Notary Public.

2 Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)

3 Birth Date
Month [ ] Day [ ] Year [ ]

4 Print Name
(This must be the same name as on your RN license.)
Last [ ] [ ] [ ] [ ] [ ] [ ] First [ ] [ ] [ ] [ ] Middle [ ] [ ] [ ] [ ]

5 Mailing Address
(You must notify the Department promptly of any address or name changes.)
Line 1 [ ] [ ] [ ] [ ] [ ] [ ] [ ] Line 2 [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Line 3 [ ] [ ] [ ] [ ] [ ] [ ] [ ] City [ ] [ ] State [ ] Zip Code [ ]
Country/Province [ ]

6 Telephone/E-Mail Address
Daytime phone [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Area Code [ ] [ ] [ ] Phone [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
E-mail Address (please print clearly) [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

7 New York State DMV ID Number
(Driver or Non-Driver ID)
[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
(Leave this blank if you do not have a New York State DMV ID Number)

8 New York State Registered Professional Nurse License Number:

Name(s) under which credentialed (if different from above): _____________________________________________________________

9 Name as it appears on degree or other credentials (if different from above):

10 Nurse Practitioner specialty area for which you are applying:

☐ Acute Care ☐ Adult Health ☐ College Health ☐ Community Health ☐ Family Health ☐ Gerontology
☐ Holistic Care ☐ Neonatology ☐ Obstetrics/Gynecology ☐ Oncology ☐ Pediatrics ☐ Palliative Care
☐ Perinatology ☐ Psychiatry ☐ School Health ☐ Womens Health

11 Identify the basis on which you are applying for a certificate. NOTE: A Form 1 & fee must be filed for each specialty area.

Name at time of graduation (if different from above):
☐ a. Completion of nurse practitioner educational program registered by the New York State Education Department as qualifying for a certificate. (File Form 2)
Program title (including specialty) __________________________________________
Institution __________________________________________ Date Graduated __________

☐ b. Completion of nurse practitioner educational program determined to be equivalent to a registered program by the State Education Department as qualifying for a certificate. (File Form 2)
Program title (including specialty) __________________________________________
Institution __________________________________________ Date Graduated __________

☐ c. Verification of passing a nurse practitioner examination administered by a national certifying organization. (File Form 3)
Examination __________________________________________ Certifying agency ________
Date Graduated __________

☐ d. On the basis of alternative requirements for graduates of nurse practitioner programs prior to April 1, 1989
☐ Experience (File Form 4) ☐ Supplemental education program (File Form 2)
**Basic Nursing Program for R.N. Licensure**

Name of school: _______________________________________________________________________________________________

City: ________________________________ State/Province: _________________________ Country: __________________________

Number of years attended: ____________________

Attendance from: _______ / _______ / _______ to _______ / _______ / _______

Graduation date: _______ / _______ / _______

**All Postsecondary Higher Education except Nurse Practitioner Program(s)**

Name of School: _______________________________________________________________________________________________

City: ________________________________ State/Province: _________________________ Country: __________________________

Major/Concentration: ___________________________________________________________________________________________

Number of years attended: ____________________

Attendance from: _______ / _______ / _______ to _______ / _______ / _______

Title of Degree/Diploma/Certificate awarded (in the original language): ____________________________________________________

Date Degree/Diploma/Certificate awarded: _______ / _______ / _______

**Nurse Practitioner Program(s)**

Name of School: _______________________________________________________________________________________________

City: ________________________________ State/Province: _________________________ Country: __________________________

Major/Concentration: ___________________________________________________________________________________________

Number of years attended: ____________________

Attendance from: _______ / _______ / _______ to _______ / _______ / _______

Title of Degree/Diploma/Certificate awarded (in the original language): ____________________________________________________

Date Degree/Diploma/Certificate awarded: _______ / _______ / _______

**Certification by national certifying organizations or state**

Name of certifying organization or state: ____________________________________________________________________________

Date originally certified: _______ / _______ / _______

Expiration date of current certification: _______ / _______ / _______
13 **Gender and Ethnicity: (This item is optional.)**

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

Gender:  
☐ Male  
☐ Female

Ethnicity:  
☐ White (not Hispanic)  
☐ Black (not Hispanic)  
☐ Asian  
☐ Hispanic  
☐ Native American

14 **Citizenship/Immigration Status:**

Federal law limits the issuance of professional licenses, registrations and limited permits to United States citizens or qualified aliens. To comply with this Federal law, complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

I am:

☐ A. A United States citizen or National.

☐ B. An alien lawfully admitted for permanent residence in the United States.

☐ C. An alien granted asylum under Section 208 of the Immigration and Nationality Act.

☐ D. A refugee granted asylum under Section 207 of the Immigration and Nationality Act.

☐ E. An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least 1 year.

☐ F. An alien whose deportation is being withheld under Section 241 (b)(3) of the Immigration and Nationality Act.

☐ G. An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.

☐ H. Non Immigrant (Temporarily in U.S.)

     Please list Visa type or immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States: ________________________________

☐ I. I do not reside in the United States.

If you checked any of the boxes from B-H, enter your alien registration number or control number issued by the United States Citizenship and Immigration Services (USCIS):

USCIS number: ________________________________

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) BY CALLING 1-800-375-5283, OR VISITING THEIR WEB SITE AT WWW.USCIS.GOV.
15 Child Support Obligation

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support*. Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits. The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A. ☐ I am not under an obligation to pay child support

OR

B. ☐ I am under an obligation to pay child support and (please check only one of the following):

☐ I am current and am not four months or more in arrears in the payment of child support; or,
☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
☐ The child support obligation is the subject of a pending court proceeding; or,
☐ I am receiving public assistance or supplemental security income; or,
☐ None of the above four statements apply.

* New York State General Obligations Law, section 3-503.

16 Affidavit With Acknowledgment (Notarization required.)

Applicant

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Signature of the applicant: ____________________________________________________________

Date __________ / __________ / __________

Month Day Year

Notary

State of __________________________________________________ County of __________________________________________________

On the ____________ day of ______________________ in the year ______________________ before me, the undersigned, personally appeared __________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature ____________________________________________________________

Notary ID number _______________________________

Expiration date __________ / __________ / __________

Month Day Year

Notary Stamp
# Certification of Professional Education

**Applicant Instructions**

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 11.

2. Send the entire form to the institution(s) you attended. Ask the registrar to complete Section II and forward both pages of the form in an official school envelope directly to the Office of the Professions at the address at the end of this form. This form will not be accepted if submitted by the applicant or any party other than the school official.

3. You must submit a separate Form 2 for each specialty area in which you are requesting a certificate.

## Section I: Applicant Information

1. **Social Security Number**
   - Leave this blank if you do not have a U.S. Social Security Number

2. **Birth Date**
   - Month
   - Day
   - Year

3. **New York State Registered Professional Nurse License Number**

4. **Print Name as It Appears on Your Application for a Certificate (Form 1)**
   - Last
   - First
   - Middle

5. **Mailing Address**
   - (You must notify the Department promptly of any address or name changes.)
   - Line 1
   - Line 2
   - Line 3
   - City
   - State
   - Zip Code
   - Country/Province

6. **Print your name as it appears on your degree or diploma.**
   - Name:

7. **School attended:**
   - (Name)
   - (city/state or country)

8. **Name of degree/diploma:**

9. **Nurse Practitioner specialty area:**
   - [ ] Acute Care
   - [ ] Adult Health
   - [ ] College Health
   - [ ] Community Health
   - [ ] Family Health
   - [ ] Gerontology
   - [ ] Holistic Care
   - [ ] Neonatology
   - [ ] Obstetrics/Gynecology
   - [ ] Oncology
   - [ ] Pediatrics
   - [ ] Palliative Care
   - [ ] Perinatology
   - [ ] Psychiatry
   - [ ] School Health
   - [ ] Womens Health

10. **Date degree/diploma awarded:**
    - mo. / day / yr.

11. **I request and give my permission to the school listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate.**

   - Applicant’s Signature
   - mo. / day / yr.
Section II: Verification of Nurse Practitioner Program

Instructions to Registrar: Please complete Section II and return both pages of this form along with an official school transcript, directly to the New York State Education Department at the address at the end of this form. This form will not be accepted if returned by the applicant or any other party.

Note: If the applicant has completed more than one program, a Form 2 must be submitted for each program.

a) It is hereby verified that: ________________________________________________
   (Section I, item 6.)
   has completed a program qualifying for certified nurse practitioner and the degree/diploma listed below has been awarded. The official program title completed by the applicant is as follows:
   
   Official program title: ________________________________________________________

b) The program contained: ___________ hours of classroom instruction and ___________ hours of preceptorship with a nurse practitioner or physician.

c) Degree/diploma awarded: ________________________________________________ Date: _______ / _______ / _______
   mo.              day                yr.

d) The individual named has completed a pharmacotherapeutics component of not less than three semester hours or the equivalent, including instruction in drug management of clients in the nurse practitioner's concentration/specialty area.
   □ Yes   □ No

e) The individual named has completed a pharmacotherapeutics component, including instruction in New York State and Federal laws related to prescriptions and record keeping.
   □ Yes   □ No

Certification

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.

Signature of Registrar: __________________________________________________________ Date: _______ / _______ / _______
   mo.               day               yr.

Title or official position: _______________________________________________________

Institution: __________________________________________________________________

Address: ____________________________________________________________________ (SEAL)

__________________________________________________________

Telephone: _______________________________ Fax: _________________________________

E-mail Address: __________________________________________________________________

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.
Verification of Instruction in New York State and Federal Laws Related to Prescriptions and Record Keeping

(Use this form ONLY if you have completed a program other than program registered by the New York State Education Department as qualifying for a certificate.)

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 8.

2. Send the entire form to the school/institution/professional association where you completed instruction in New York State and federal laws relating to prescriptions and record keeping. Ask them to complete Section II and forward both pages of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required. This form will not be accepted if submitted by the applicant or any party other than the school official.

Section I: Applicant Information

1. Social Security Number 2. Birth Date

(Leave this blank if you do not have a U.S. Social Security Number)

3. New York State Registered Professional Nurse License Number

4. Print Name as It Appears on Your Application for a Certificate (Form 1)

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

5. Mailing Address (You must notify the Department promptly of any address or name changes.)

<table>
<thead>
<tr>
<th>Line 1</th>
<th>Line 2</th>
<th>Line 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td></td>
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<tr>
<td>State</td>
<td>Zip Code</td>
<td></td>
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<tr>
<td>Country/Province</td>
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<td></td>
</tr>
</tbody>
</table>

6. Print name under which course was completed (if different from above).

Name: ________________________________________________________________

7. Name of school/institution/professional association where course was completed:

______________________________

Address: ______________________________________________________________

8. I request and give my permission to the school/institution/professional association listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate.

Applicant’s Signature _____________________________________________

Date: ___________ / _________ / _______
Section II: Verification of Completion of Prescription Course

Instructions to School/Institution/Professional Association: Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of this form. This form will not be accepted if returned by the applicant or any other party.

1. It is hereby verified that: __________________________________________________________
   (Section I, item 6)
   completed instruction in New York State and federal laws related to prescriptions and record keeping.

2. This course was:  
   ☐ part of nurse practitioner program, or  
   ☐ supplementary course.

3. Date(s) of the course: _______ / _______ / _______ and _______ / _______ / _______
   mo.              day                yr.          mo.              day                yr.

4. The length of the course was: _______________________ or ______________________.
   (semester hours) (clock hours)

Attestation

I hereby attest that to the best of my knowledge and belief the information in Section II is an accurate record of the completion of a course in prescription and record keeping laws of the individual named on this form.

Signature: ____________________________________________________________________  Date: _______ / _______ / _______
   mo.               day               yr.

Print Name: ____________________________________________________________________

Title or official position: __________________________________________________________

Institution: _____________________________________________________________________

Address: ______________________________________________________________________
   (SEAL)

Telephone: _______________________________ Fax: _________________________________

E-mail Address: _________________________________________________________________

Return Directly to:   New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.

Nurse Practitioner Form 2B, Page 2 of 2, (Rev. 3/09)
Verification of Pharmacotherapeutics Course
(Three Semester Hours or the Equivalent)
(Use this form ONLY if you have completed a program other than program registered by the New York State Education Department as qualifying for a certificate.)

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 8.
2. Send the entire form to the school/institution/professional association where you completed a pharmacotherapeutics course, including instruction in drug management of clients in the nurse practitioner’s specialty area. Ask them to complete Section II and forward both pages of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required. This form will not be accepted if submitted by the applicant or any party other than the school official.

Section I: Applicant Information

1. Social Security Number
2. Birth Date Month Day Year
   (Leave this blank if you do not have a U.S. Social Security Number)
3. New York State Registered Professional Nurse License Number
4. Print Name as It Appears on Your Application for a Certificate (Form 1)
   Last
   First
   Middle
5. Mailing Address (You must notify the Department promptly of any address or name changes.)
   Line 1
   Line 2
   Line 3
   City
   State
   Zip Code
   Country/Province
6. Print name under which course was completed (if different from above).
   Name: ___________________________________________________________
7. Name of school/institution/professional association where course was completed:
   Address: _________________________________________________________
8. I request and give my permission to the school/institution/professional association listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate.
   Applicant’s Signature _________________________________ mo. / ___/ ___
Section II: Verification of Completion of Pharmacotherapeutics Course

Instructions to School/Institution/Professional Association: Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of this form. This form will not be accepted if returned by the applicant or any other party.

1. It is hereby verified that: ____________________________________________________________ (Section I, item 6)
   has completed pharmacotherapeutics instruction in drug management of clients in the nurse practitioner's specialty area of ______________________________________________________.

2. This course was ☐ part of nurse practitioner program, or
   ☐ supplementary course.

3. The inclusive date(s) of the course were: _______ / _______ / _______ and _______ / _______ / _______.
   mo.              day               yr.     mo.              day               yr.

4. The length of the course was: _______________ or _______________.
   (Semester hours) (Clock hours)

5. In this course, did the individual named receive instruction in New York State and Federal laws relating to prescriptions and record keeping?
   ☐ Yes   ☐ No

Attestation

I hereby attest that to the best of my knowledge and belief the information in Section II is an accurate record of the completion of a course in pharmacotherapeutics by the individual named on this form.

Signature: ____________________________________________ Date: _______ / _______ / _______ mo.               day               yr.

Print Name: ____________________________________________

Title or official position: ________________________________

Institution: ____________________________________________

Address: ____________________________________________ (SEAL)

_____________________________________________________

Telephone: _______________________________ Fax: _______________________________

E-mail Address: ________________________________________

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.

Nurse Practitioner Form 2C, Page 2 of 2, (Rev. 3/09)
Verification of National Nurse Practitioner Examination
(Use this form ONLY if you are seeking a New York State certificate through a national certifying organization.)

 Applicant Instructions
1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 9.
2. Send the entire form to the national certifying organization. Ask them to complete Section II and forward both pages of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required. This form will not be accepted if submitted by the applicant or any other party.

Section I: Applicant Information
1. Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)
2. Birth Date Month □ Day □ Year □
3. New York State Registered Professional Nurse License Number
4. Print Name as It Appears on Your Application for a Certificate (Form 1)
Last □□□□ First □□□□ Middle □□□□
5. Mailing Address (You must notify the Department promptly of any address or name changes.)
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6. National certifying organization: ____________________________________________________________
Certification examination passed: Title: __________________________ Date: ________ / ________ / ________
   mo.     day     yr.
7. Are you currently certified? □ Yes □ No
   If yes, certification number: __________________________________________ Expiration date: ________ / ________ / ________
   mo.     day     yr.
8. Print name under which certificate was awarded (if different from above).
   Name: ________________________________________________________________________________
9. I request and give my permission to the national certifying organization listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate.
   Applicant’s Signature ___________________________________________ ________ / ________ / ________
   mo.     day     yr.
Section II: Verification of National Nurse Practitioner Examination

Instructions to National Certifying Organization: Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of this form. This form will not be accepted if returned by the applicant or any other party.

1. It is hereby verified that: __________________________________________________________________________________________
   has passed the nurse practitioner certification examination listed below.

2. Certification examination title: ______________________________________________________________________________________
   Certificate awarded: (Title) ________________________________________________________________________________________
   Certificate number: __________________________________________ Date initial certificate awarded: _______ / _______ / _______
   mo.               day               yr.
   Is this nurse currently certified?  ☐ Yes ☐ No Expiration date: _______ / _______ / _______
   mo.               day               yr.

3. Education program that was basis for admission to the examination:
   Program ______________________________________________________________________________________________________
   Entrance date _______ / _______ / _______ Completion date _______ / _______ / _______
   mo.               day               yr. mo.               day               yr.
   Degree/diploma awarded: __________________________________________________________ Date: _______ / _______ / _______
   mo.               day               yr.
   Institution:  ____________________________________________________________________________________________________
   Address: ______________________________________________________________________________________________________

Certification

I hereby certify that to the best of my knowledge and belief the information in Section II is an accurate record of the examination results of the individual named on this form.

Signature: ____________________________________________________________________ Date: _______ / _______ / _______
   mo.               day               yr.
Print Name: ______________________________________________________________________________________________________
Title: ________________________________________________________________________
Agency: _______________________________________________________________________
Address: _______________________________________________________________________
   (SEAL)
Telephone: _______________________________ Fax: _________________________________
E-mail Address: _________________________________________________________________

Return Directly to:   New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.
Verification of Experience

(Use this form ONLY if you are following pre-1989 alternative requirements for a certificate.)

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 7.
2. Send the entire form to the physician who has been responsible for supervising the work for which you are seeking credit and ask her/him to complete Section II and send both pages of the form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant or any other party.**
3. A separate form 4 must be provided by each physician with whom you worked while acquiring the required experience.

Section I: Applicant Information

1. Social Security Number [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
   (Leave this blank if you do not have a U.S. Social Security Number)
2. Birth Date
   Month [ ] [ ] Day [ ] [ ] Year [ ] [ ]
3. New York State Registered Professional Nurse License Number [ ] [ ] [ ] [ ] [ ] [ ] [ ]
4. Print Name as It Appears on Your Application for a Certificate (Form 1)
   Last [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
   First [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
   Middle [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
5. Nurse practitioner specialty area for which you are applying: ____________________________________________________________
6. Name of supervising physician: ________________________________________________________________________________
7. I authorize the physician named above to provide any information requested, including the information requested on this form, to the New York State Education Department.
   Applicant’s Signature ___________________________ mo. / day / yr.

Section II: Verification of Experience - To be completed by the Supervising Physician

The individual named above is seeking certification as a nurse practitioner in the specialty area named in (5) above. **This application is partially based upon two years of experience prior to April 1, 1989, at least one year of which shall be subsequent to April 1, 1986, in the provision of primary health care services in a health care facility licensed pursuant to Article 28 of the Public Health Law or in a school health demonstration project.** The purpose of this objective performance evaluation is to determine the competency of the nurse practitioner to provide primary care in the specified specialty area. It is a summary evaluation based upon your firsthand observation, anecdotal notes, and other documentation of the applicant’s consistent performance.

The rating is either “satisfactory,” “unsatisfactory,” or “not applicable.” A checkmark will indicate the rating. There is space at the end of the form to provide any additional comments you may have regarding the performance of this individual (attach additional sheets, if required).

Please complete Section II, sign and date the certification and return both pages of this form directly to the Office of the Professions at the address at the end of the form.

Name of Institution: ________________________________________________________________________________
Address: __________________________________________________________________________________________

Article 28 facility? □ Yes □ No If yes, since: __________________________________________________________________________ Year

In what capacity was the applicant employed? __________________________________________________________________

□ Full time □ Part time Inclusive dates (note interruptions): From ______ / ______ / ______ to ______ / ______ / ______

mo. day yr. mo. day yr.

Specialty or clinical area of experience: __________________________________________________________________

If available, please attach job description.
### Section II: Verification of Experience (Continued) - To be completed by the Supervising Physician

#### Summary Performance Evaluation

<table>
<thead>
<tr>
<th>A. Health Assessment</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
<th>Does not apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrates skillful interviewing of clients.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Elicits an age-appropriate comprehensive health history.</td>
<td></td>
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</tr>
<tr>
<td>3. Elicits and records information specific to the client’s complaints (e.g., onset, timing, duration, location, associated symptoms, alleviating factors, quantity/intensity, etc.).</td>
<td></td>
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<tr>
<td>4. Performs a complete physical examination.</td>
<td></td>
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<tr>
<td>5. Demonstrates use of appropriate techniques of inspection, palpation, percussion, and auscultation throughout the examination.</td>
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<tr>
<td>6. Prepares client charts for review according to the facilities schedule.</td>
<td></td>
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<tr>
<td>7. Differentiates normal from abnormal findings.</td>
<td></td>
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<tr>
<td>8. Uses appropriate equipment accurately &amp; efficiently when performing a physical examination.</td>
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<tr>
<td>9. Adapts the history and physical to meet the needs of individual clients.</td>
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<td></td>
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<tr>
<td>10. Selects appropriate diagnostic tests to gather information necessary to evaluate the health status of a client.</td>
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<tr>
<td>11. Records information in a well-organized, concise manner.</td>
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<tr>
<td>12. Analyzes all data in order to formulate an assessment of the client’s status and establish a plan of care.</td>
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</tr>
<tr>
<td>13. Identifies specific health promotion/maintenance needs of clients and families.</td>
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<td></td>
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<tr>
<td>14. Describes etiology, developmental considerations, pathogenesis and clinical manifestations of specific disease processes.</td>
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<tr>
<td>15. Correlates pathophysiology with client’s signs &amp; systems.</td>
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<tr>
<td>16. Correlates pathophysiology with laboratory data.</td>
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<tr>
<td>17. Demonstrates knowledge of pathophysiology of acute and chronic diseases or conditions commonly encountered in the practice setting.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Technical Skills</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Performs and interprets selected laboratory tests.</td>
<td></td>
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<tr>
<td>2. Performs technical skills specific to practice setting.</td>
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<tr>
<td>3. Performs therapeutic maneuvers skillfully.</td>
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</table>

<table>
<thead>
<tr>
<th>C. Management of Acute and Chronic Illnesses</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Assesses and manages most common acute illnesses according to areas of preparation, age of client, legal parameters and current standards of practice.</td>
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<tr>
<td>2. Assesses and manages stable chronic illnesses according to areas of preparation, age of client, legal parameters and current standards of practice.</td>
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<tr>
<td>3. Identifies and manages emergency or crisis situations.</td>
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<tr>
<td>4. Collaborates with health team members and makes appropriate referrals.</td>
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<tr>
<td>5. Demonstrates diagnostic reasoning ability in formulating assessments.</td>
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</tbody>
</table>

Please attach a comment on the applicant’s overall competence to provide primary care services in the designated specialty area.

### Certification

I certify that the information provided in Section II of this form is complete and accurate to the best of my knowledge and that I have personally supervised the person named in this form in the performance of the competencies listed above.

Physician signature: ___________________________________________ Date: _____ / _____ / _____

Print name: _________________________________________________

Title: _______________________________________________________

New York State medical license number: _________________________

 Telephone: ___________________________ Fax: _____________________

E-mail: _____________________________________________________

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.

Nurse Practitioner Form 4, Page 2 of 2, (Rev. 3/09)
Verification of Collaborative Agreement and Practice Protocol

Applicant Instructions
1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1).
2. You and the initial collaborating physician with whom you have a practice agreement and practice protocol must complete Sections II and III and return both pages of the form to the Office of the Professions at the address at the end of the form. Be sure to sign and date item 4 in Section III.

Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is only required once.

Section I: Applicant Information

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>Social Security Number</td>
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<tr>
<td></td>
<td>(Leave this blank if you do not have a U.S. Social Security Number)</td>
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<tr>
<td>2</td>
<td>Birth Date</td>
<td>Month</td>
<td>Day</td>
<td>Year</td>
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<tr>
<td>3</td>
<td>If Already Certified, New York State Nurse Practitioner Certificate Number</td>
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<td>4</td>
<td>Print Name as It Appears on Your Application for a Certificate (Form 1)</td>
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<td>Middle</td>
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<td>5</td>
<td>Mailing Address (You must notify the Department promptly of any address or name changes.)</td>
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<td>City</td>
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<td></td>
<td>State</td>
<td></td>
<td>Zip Code</td>
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<td></td>
<td>Country/Province</td>
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</table>

Section II: Collaborating Physician

1. Name of collaborating physician: __________________________ Last First Middle
2. Address: __________________________________________________________
3. Telephone: __________________ Fax: __________________
4. E-mail address: __________________________________________________
5. New York State medical license number: __________________________
6. Area of current practice: ________________________________________
7. Area of specialty practice: _______________________________________

Nurse Practitioner Form 4NP, Page 1 of 2, (Rev. 3/09)
Section III: Practice Protocol

Instructions: You must use an approved practice protocol text that is a standard publication. Please select a protocol text from the approved list (see application instructions, pages 8-9) and submit this form to the Department at the address at the end of the form, no later than 90 days after the commencement of practice.

1. List title, publisher, and date of publication of the approved protocol text.

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

2. Location and description of practice site(s): (clinic, private office, HMO, etc.)

<table>
<thead>
<tr>
<th>Practice Site</th>
<th>Name</th>
<th>Address</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

3. Description of practice including any mutually agreed upon exceptions:

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

4. We hereby verify that we have a written a collaborative agreement and have selected a practice protocol(s).

Nurse Practitioner signature: ____________________________ Date: _______ / _______ / _______

Collaborating Physician signature: ____________________________ Date: _______ / _______ / _______

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.
INSTRUCTIONS

Use this form to report a change in your address and/or name. Please read these instructions carefully and be sure you complete the appropriate sections of this form. Please print clearly in ink.

• **For address changes only**: Complete Sections I, II, and IV. **For address changes only**, you may fax this form to the Records and Archives Unit at 518-486-3617 or provide the required information by e-mailing oparchiv@mail.nysed.gov. Your records will be updated. Currently registered licensed professionals will be sent a new registration certificate.

• **For name changes only**: Complete Sections I, III, and IV. **Name changes** must be accompanied by supporting documentation.

Acceptable supporting documentation includes:

A court order authorizing your name change, marriage certificate, or divorce papers and a copy of a photo ID in your new name.

Or

**Two (2) of the following:**

- A letter from the Social Security Administration indicating both your old and new names.
- Copies of both old and new driver’s licenses.
- Copies of both old and new New York State non-driver photo ID cards.
- Copies of both old and new Social Security Cards.
- Copies of both old and new passports.
- Copies of both old and new U.S. Military photo ID cards.

Other forms of identification may be acceptable as supporting documentation. Please contact the Records/Archives Unit by calling 518-474-3817 Ext. 380 or by e-mailing oparchiv@mail.nysed.gov before submitting.

Be sure to sign and date Section IV. Currently registered licensed professionals will be sent a new registration certificate. Also, if you would like to replace your existing license parchment with one in your **new** name, check the appropriate box in Section III and enclose your **original parchment** (your original parchment will be letter sized, 8.5 x 11 inches, and will not have your address on it).

• **For address and name changes**: Complete all sections.

Licensed professionals can check the Office of the Professions’ Web site at www.op.nysed.gov to verify your name, city, state, registration expiration date, and license number on record.

NOTE: Important information and registration renewals will be sent to the address on file for you. **You must notify the Department in writing within 30 days if your address or name changes.**

Section I: Your General Information

1. Name (currently on record): ________________________________________________________________

2. Social Security Number: _______ _______ _______ _______ _______ _______ _______
   Birth Date: Month _______ Day _______ Year _______

   Telephone: Home: _______ - _______ - _______ - _______
   Work: _______ - _______ - _______ - _______

   E-mail: __________________________________________ Fax: _______ - _______ - _______ - _______

3. Are you reporting an address and/or name change?  
   ☐ address change  ☐ name change  ☐ both

4. Effective date of change: _______ / _______ / _______  
   (Note: Changes cannot be accepted until after the effective date.)

5. Licensure status in New York State:
   
   ☐ I am an applicant for licensure in New York State for the licensed profession(s) of: ____________________________
   (see list of professions on page 2)

   ☐ I am currently licensed in New York State in the profession(s) of:
   (see list of professions on page 2)

   ____________________________ New York State license number: _______ _______ _______ _______ _______ _______

   ____________________________ New York State license number: _______ _______ _______ _______ _______ _______

   ____________________________ New York State license number: _______ _______ _______ _______ _______ _______

   ____________________________ New York State license number: _______ _______ _______ _______ _______ _______
### Address Change (please print)

<table>
<thead>
<tr>
<th>Information Currently On Record</th>
<th>New Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apt./Bldg. ______________________</td>
<td>Apt./Bldg.</td>
</tr>
<tr>
<td>Street _________________________</td>
<td>Street</td>
</tr>
<tr>
<td>City ___________________________</td>
<td>City</td>
</tr>
<tr>
<td>State __________________________</td>
<td>State</td>
</tr>
<tr>
<td>Zip Code _________ - _________</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Province or Country (if not U.S.)</td>
<td>Province or Country (if not U.S.)</td>
</tr>
</tbody>
</table>

**Is this new address a business address?**
- [ ] Yes
- [ ] No

Failure to answer this question will result in your address being deemed a business address and, therefore, public information.

### Name Change (please print)

If you are reporting a name change, please sign using your **NEW** name in Section IV. If you are currently registered you will receive a new registration certificate.

<table>
<thead>
<tr>
<th>Information Currently On Record</th>
<th>New Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name ______________________</td>
<td>Last Name</td>
</tr>
<tr>
<td>First Name _____________________</td>
<td>First Name</td>
</tr>
<tr>
<td>Middle or Initial _______________</td>
<td>Middle or Initial</td>
</tr>
</tbody>
</table>

Check here if you wish to have your existing license parchment replaced with one in your **NEW** name. Enclose your original parchment and a $10 check or money order made payable to the New York State Education Department with your request. You will be sent a new parchment. **Note:** your original parchment will be letter sized, 8.5 x 11 inches, and will **not** have your address on it.

### Affidavit

I **declare and affirm** that the statements above are true, complete, and correct. I understand that any false or misleading information in, or in connection with, my application or this notification may be cause for denial or loss of licensure and may result in criminal prosecution.

______________________________
Signature

______________________________
Date

### Professional Titles Licensed Under Education Law

(See item #5 on page 1 of the form.)

- Acupuncturist
- Architect
- Athletic Trainer
- Audiologist
- Certified Clinical Laboratory Technician
- Certified Dental Assistant
- Certified Histological Technician
- Certified Public Accountant
- Certified Shorthand Reporter
- Chiropractor
- Clinical Laboratory Technologist
- Creative Arts Therapist
- Cytotechnologist
- Dental Hygienist
- Dentist
- Dietitian/Nutritionist
- Interior Designer
- Landscape Architect
- Land Surveyor
- Licensed Clinical Social Worker
- Licensed Master Social Worker
- Licensed Practical Nurse
- Marriage and Family Therapist
- Massage Therapist
- Medical Physicist
- Mental Health Counselor
- Midwife
- Nurse Practitioner
- Occupational Therapist
- Occupational Therapy Assistant
- Ophthalmic Dispenser
- Optometrist
- Perfusionist
- Pharmacist
- Physical Therapist
- Physical Therapist Assistant
- Physician
- Podiatrist
- Polysomnographic Technologist
- Professional Engineer
- Psychoanalyst
- Psychologist
- Public Accountant
- Registered Physician Assistant
- Registered Professional Nurse
- Registered Specialist Assistant
- Respiratory Therapist
- Respiratory Therapy Technician
- Speech-Language Pathologist
- Veterinarian
- Veterinary Technician

### Applicants mail to

New York State Education Department, Office of the Professions, Division of Professional Licensing Services, (insert name of profession from above list) Unit, 89 Washington Avenue, Albany, NY 12234-1000.

### Licensees mail to

New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Records and Archives Unit, 89 Washington Avenue, Albany, NY 12234-1000.