---FORM 1R---

MISSISSIPPI BOARD OF NURSING
713 S. Pear Orchard Road, Suite 300
Ridgeland, MS 39157
Telephone: (601) 957-6300
Fax: (601) 957-6301
www.msbn.ms.gov

OFFICE USE ONLY

Application Complete

____/____/____

APPLICATION FOR RESTORATION OF A NURSING LICENSE

(PRINT OR TYPE ALL INFORMATION)

PART A - GENERAL INFORMATION

NAME: _____
Last First Middle

Social Security Number: _____

Date of Birth: ____/____/____
Mo. Day Yr.

Other names or aliases you have been known by: _____

Legal Mailing Address: _____ Telephone (____) ____-____
Box or Street Work

_____ Telephone (____) ____-____
City State Zip Code Home

_____ Telephone (____) ____ -____
E-mail Cell

APRN _____ Certification Type: _____

Registered Nurse ____ Mississippi RN License No: R - _____

Licensed Practical Nurse _____ Mississippi LPN License No: P - _____

Are you represented by an attorney in this matter? ☐ YES ☐ NO
If yes, state name, address and telephone number below:

_____ (____) ____- _____
Attorney Name Telephone

_____
Address City State Zip Code

My primary state of residence is ( ) Mississippi ( ) other state (specify) _____

For a list of COMPACT STATES, visit www.ncsbn.org

PART B - GENERAL QUESTIONS

OTHER than the actions associated with the revocation/surrender/suspension/denial of your license,

1. Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? ☐ YES ☐ NO

2. Are there any pending criminal charges against you? ☐ YES ☐ NO

3. Have you been found guilty of professional misconduct, unprofessional conduct, incompetence, or negligence in any state or country other than Mississippi? ☐ YES ☐ NO

4. Has any licensing authority (other than Mississippi) suspended, revoked or restricted your license or imposed any other disciplinary action? ☐ YES ☐ NO

5. Have you ever had charges brought against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country other than Mississippi? ☐ YES ☐ NO

6. Are you currently on any licensure or court ordered probation? ☐ YES ☐ NO

7. Have you ever been requested to appear before or submit an explanation to any licensing authority in regard to charges or complaints? ☐ YES ☐ NO

8. Have you ever been denied a license or the opportunity to take an examination for licensure by any licensing authority? ☐ YES ☐ NO

9. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures? ☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PROVIDE A FULL EXPLANATION ON A SEPARATE SHEET OF PAPER FOR EACH ITEM. YOU MUST INCLUDE ANY VERIFYING DOCUMENTATION FOR EACH ITEM.

10. Have you ever received counseling or treatment connected with the revocation /surrender/suspension/denial of your license? ☐ YES ☐ NO

If yes, (1) attach a statement from the treating practitioner/facility regarding your current diagnosis and prognosis, including your ability to resume the practice of nursing, and (2) present an executed release to each practitioner or facility where you have had treatment to have treatment records submitted directly to the Board. Treatment records must include the Intake, Admission Diagnosis, Plan of Treatment, Discharge Summary, Discharge Diagnosis and Recommendations. A release form has been enclosed for your convenience.

11. List the following requested information for each counseling or treatment received which is related to the reason for the revocation/surrender/suspension/denial of your license.

FROM MONTH-YEAR	TO MONTH-YEAR	TYPE OF TREATMENT	PLACE & ADDRESS OF TREATMENT

PART C - LICENSURE STATUS

1. Are you licensed or have you ever held a nursing or health related license in any other state or country? ☐ YES ☐ NO

If yes, list each jurisdiction. A Verification of Licensure in Another Jurisdiction (Form 3R) must be submitted for each license (including all inactive licenses) listed.

State or Country	Type of Licensure	Date License Issued	Any Limitations on License	If License is not Current, Explain Below or on Separate Sheet

2. Have you ever held or do you currently hold a Mississippi license in another profession? ☐ YES ☐ NO

If yes, complete section below.

Profession	License Number	Date of Licensure	Current Status

PART D - CONTINUING EDUCATION

1. List any continuing education credits you earned since the revocation/surrender/suspension/denial of your license. Submit proof for each item listed. If additional space is required, attach a separate list.

COURSE/SEMINAR ATTENDED	DATE(S) OF ATTENDANCE	CREDIT HOURS	CHECK ONE OPTION
			☐ ON-LINE ☐ ATTENDED CLASS
			☐ ON-LINE ☐ ATTENDED CLASS
			☐ ON-LINE ☐ ATTENDED CLASS
			☐ ON-LINE ☐ ATTENDED CLASS

2. List other methods, if any, that you have used to maintain/improve your knowledge and skill in the practice of your profession since the date of revocation/surrender/suspension/denial of your license. If additional space is required, attach a separate list.

3. Explain how the educational preparation (listed in items 1 & 2 above) is relevant to the specific conduct that resulted in the loss of your license.

PART E - COMMUNITY SERVICE

List any community or public service related activities you have been involved in since the date of the revocation/surrender/suspension/denial of your license. Submit documentation for each activity listed. If additional space is required, attach a separate sheet.

Type of Activity	Name of Organization	Date(s)	Number of Hours

PART F - EMPLOYMENT HISTORY

List all employment chronologically since graduation from your nursing school to the present. Explain periods of unemployment. If additional space is required, attach a separate sheet. Begin with date of graduation from your nursing school and end with the present date.

FROM Month – Year	TO Month – Year	Reason for Employment Termination /Resignation	Employers
			Employer: Address: Position held: Telephone (_ _ _) _ _ _ - _ _ _ _ Duties:
			Employer: Address: Position held: Telephone (_ _ _) _ _ _ - _ _ _ _ Duties:
			Employer: Address: Position held: Telephone (_ _ _) _ _ _ - _ _ _ _ Duties:

PART G - PROFESSIONAL REHABILITATION ACTIVITIES

List any professional practice-related rehabilitation activities which you have undertaken to address the action(s) which resulted in the loss or denial of your license. Submit documentation for each activity listed. If additional space is required, attach a separate sheet.

_____

_____

_____

_____

_____

_____

_____

_____

PART H - SUBMISSION OF AFFIDAVITS

An application for restoration will not be considered complete without at least 5 notarized supporting affidavits (Form 4R) attached. Three of the required five affidavits must be from individuals licensed and in good standing in your profession. List the names and telephone numbers of the individuals for which you have attached affidavits. If additional space is required, attach a separate sheet. Include the required affidavits along with this application for restoration form and return to the address shown below.

Name _____ Telephone Number_____

Name _____ Telephone Number_____

Name _____ Telephone Number_____

Name _____ Telephone Number_____

Name _____ Telephone Number_____

PART I - CERTIFICATION

Under penalties of perjury, 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.

_____ _____

Signature of Petitioner Date

Sworn to before me this ____ Day of _____, _____.

_____

Signature of Notary

(SEAL)

ATTACH A RECENT INDIVIDUAL PASSPORT TYPE PHOTOGRAPH

RETURN TO: Mississippi Board of Nursing, 713 S. Pear Orchard Rd., Ste. 300, Ridgeland, MS 39157

---FORM 2R---

MISSISSIPPI BOARD OF NURSING

713 S. Pear Orchard Road, Suite 300
Ridgeland, MS 39157
Telephone: (601) 957-6300
Fax: (601) 957-6301
www.msbn.ms.gov

This form is to be completed ONLY by applicants who answered "YES" to question # 9 in Part B of Form 1R.

AUTHORIZATION TO RELEASE TREATMENT RECORDS

INSTRUCTIONS: If you answered "Yes" to question # 10 in Part B of the Application Form 1R, you must complete a separate authorization form for each professional practitioner and/or hospital/facility where you have been treated. Please attach the records for each provider to the Release. If additional forms are needed, this form may be photocopied. DO NOT MAIL THIS AUTHORIZATION SEPARATELY. **Completed authorizations must be attached to your application for restoration.**

I, (print your name here) _____, request and authorize the **below-named** licensed professional or practitioner or the **below-named** hospital or facility, to disclose fully to the Mississippi Board of Nursing and its authorized representatives all information and records relating to the diagnosis, treatment, prognosis made for and/or on my behalf, or service rendered for and/or on my behalf, by the said licensed professional, practitioner, hospital, or facility. I understand that this consent may be withdrawn by me at any time except to the extent that the action has been taken in reliance upon it. In any event, this consent shall expire when the Mississippi Board of Nursing has taken final action on my petition for restoration of my license. I also understand that my disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Name of practitioner _____ License No. _____

or

Name of hospital or other facility_____

Signature of petitioner_____ Date _____

---FORM 3R---

MISSISSIPPI BOARD OF NURSING

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Telephone: (601) 957-6300
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This form is to be completed ONLY by applicants who are or have been licensed in another jurisdiction

VERIFICATION OF LICENSURE IN ANOTHER JURISDICTION

APPLICANT INSTRUCTIONS

1. Complete Sections I and II. Enter your name as it appears on your Application.
2. **DO NOT RETURN THIS FORM WITH YOUR APPLICATION**. Send this form to each state or country where you are or have ever been licensed and request that they complete Section III. Be sure to include any fee(s) required. If additional forms are needed, this form may be photocopied. You must provide Verification of Licensure and the status of your license from ALL jurisdictions where you are or have ever been licensed. Verifications must be in English or otherwise submitted with an official translation.

SECTION I: APPLICANT INFORMATION

1. Social Security Number _____ - ____ - _____ 2. Birth date _____ /_____/ _____
Mo. Day Yr.

3. Full Name: Last _____

First _____

Middle _____

4. Address: Street _____

City _____

State _____ Zipcode _____

5. Name of Jurisdiction: _____ Date of Licensure: ____/____/_____
Mo. Day Yr.

6. Name under which you are or were licensed in that jurisidiction:

_____

License Number _____ License Type _____

SECTION II: APPLICANT RELEASE

I request and authorize the above named jurisdiction to release any and all information pertaining to my license, including but not limited to, disciplinary actions and pending charges.

Signature of Applicant _____Date_____

JURISDICTION'S CERTIFICATION IS TO BE COMPLETED ON NEXT PAGE

SECTION III: OTHER JURISDICTION'S CERTIFICATION.

To be completed by the licensing authority.

Do not return to Applicant.

Return completed form to: Mississippi Board of Nursing,
713 S. Pear Orchard Rd., Ste. 300,
Ridgeland, MS 39157.

1. a. Has the applicant named in Section I been subject to any disciplinary action? ☐ YES ☐ NO

   b. Are any charges pending against this individual? ☐ YES ☐ NO

If the answer to either of these questions is "yes", please attach certified copies all relevant information.

2. License Number _____ Date Issued ____ / ____ / _____
   Mo. Day Yr.

   Expiration of most recent registration ____ /____/ _____ Is the license current? ☐ YES ☐ NO
   Mo. Day Yr.

   Is the license: ☐ Single State ☐ Multi State

   I certify that the information shown above is true and correct, according to the records of this office.

   Name of Jurisdiction: _____

   Name: _____

   Title: _____ (BOARD SEAL)

   Signature: _____

   Date: _____

   Telephone Number: (____) ____ - _____

   FAX Number: (____) ____ - _____

SECTION IV: OPTIONAL COMMENTS. To be completed by the licensing authority.

Comments_____

_____

_____

_____

_____

_____

_____

_____

---FORM 4R---

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SUPPORTING AFFIDAVIT

INSTRUCTIONS

APPLICANT: Complete items A and B and provide a copy to each of your affiants/references. Attach completed original of each affidavit to your restoration application.

AFFIANT/REFERENCE: Complete items 1 - 5, **sign** the affidavit in the presence of a notary public, and return the form to the applicant.

In the Matter of the Application of:

A. _____
(Applicant's Name)

for the restoration of (his/her) license to practice as a

B. _____
(Type of License)

This affidavit is in support of an application for restoration of a nursing license.

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1. My name is _____.
(affiant/reference name)

I reside at _____.
(affiant/reference address)

My Daytime telephone number (include area code) is _____.

My occupation is _____.

I am a licensed professional ☐ YES ☐ NO

If yes, Profession: _____State:_____

License Number: _____

I am of sound mind, capable of making this affidavit and personally acquainted with the facts stated herein.

I make this affidavit in support of_____ application for the restoration of (his/her) license to practice as a _____in the State of Mississippi.

2. I have known the applicant for _____ years and _____ months through the following contacts:

_____

_____

_____

3. It is my understanding that the applicant's license was revoked, surrendered, suspended or denied because (provide a detailed statement of circumstances which led to revocation/surrender/suspension/denial of license):

4. It is my understanding that the applicant has undertaken the following activities to rehabilitate (himself/herself) (provide a detailed statement of activities):

5 I recommend that the applicant's license be restored because:

(Signature of Affiant/Reference)

FOR NOTARY USE ONLY

Sworn to before me this _____ Day of _____, _____.

Notary Public_____

(SEAL)