FSM NATIONAL BOARD OF NURSING LICENSURE
Department of Health Services
P.O. Box PS 70
PALIKIR, POHNPEI FM 96941
TEL.: (691) 320-2619/2643
FAX: (691) 320-5263

APPLICATION FOR NURSING LICENSURE

A. GENERAL INFORMATION AND INSTRUCTIONS

PLEASE PRINT OR TYPE

1. TYPE OR LICENSURE REQUESTED:

		Initial	Renewal	Application Fee (Non-refundable)
LPN	☐	☐ $10	☐ $ 5	☐ $ 5
RN	☐	☐ $20	☐ $10	☐ $ 5
RN/APN	☐	☐ $30	☐ $15	☐ $ 5

2. LICENSE CURRENT THRU _____; FEE ENCLOSED [ ]
3. THE BOARD SHALL NOT BE RESPONSIBLE FOR CASH PAYMENT. MAKE CHECK PAYABLE TO "NATIONAL BOARD OF NURSING".
4. CHANGE IN NAME AND/OR ADDRESS.
5. APPLICATION MUST BE RECEIVED NO LATER THAN JULY 31, _____; OTHERWISE, THE REINSTATEMENT FEE OF $20 FOR LPN, $30 FOR RN AND/OR $40 FOR RN/APN SHALL BE CHARGED & PAYMENT MADE PRIOR TO PROCESSING OF APPLICATION.
6. UNSIGNED APPLICATION WILL BE RETURNED FOR SIGNATURE BEFORE PROCESSING.
7. SUBMISSION OF COMPLETED APPLICATION:

MAIL TO:	HANDCARRIED:
FSM NATIONAL BOARD OF NURSING P.O. BOX PS 70 PALIKIR, POHNPEI 96941	PRESENT TO TREASURER OF FSM WITH PAYMENT THEN BRING PROCESSED FORM TO FSM-NBN OFFICE FOR ISSUANCE OF LICENSE. PAYMENT CAN BE MADE AT DEPT. OF HEALTH SERVICES.

B. . IDENTIFICATION

1. _____
NAME *(LAST)* *(FIRST)* *(MIDDLE)* SIGNATURE DATE

2.

FSM LICENSE NUMBER	DOB *(MONTH/DAY/YEAR)*	SOCIAL SECURITY NUMBER	SEX	PHONE NO.

3. MAILING ADDRESS, INCLUDING WORK AND HOME TELEPHONE NUMBERS:

_____

C. NURSING SURVEY

PLEASE CHECK APPROPRIATE BOX PER CATEGORY

1. MARITAL STATUS ☐ NEVER MARRIED ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ OTHER
2. AGE GROUP ☐ 25 & UNDER ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56+

3. EMPLOYMENT RECORD	☐ 1. EMPLOYED IN NURSING FULL TIME? ☐ 2. EMPLOYED IN NURSING PART TIME? ☐ 3. AVERAGE NUMBER OF HOURS PER WEEK ☐ 4. AVERAGE NUMBER OF WEEKS PER YEAR? ☐ 5. EMPLOYMENT OUTSIDE NURSING FULL TIME: ☐ 6. LAST DATE EMPLOYED RN-LPN. ☐ 7. EMPLOYED OUTSIDE NURSING PART TIME: ☐ 8. UNEMPLOYED: NOT SEEKING EMPLOYMENT IN ANY FIELD	☐ 9. UNEMPLOYED SEEKING EMPLOYMENT AS NURSE PART TIME: ☐ 10. UNEMPLOYED SEEKING EMPLOYMENT AS NURSE FULL TIME: ☐ 11. HOW LONG HAVE YOU BEEN SEEKING EMPLOYMENT AS NURSE? NO. OF DAYS ___ WEEKS ___

4. MOST RECENT EMPLOYER	_____	PHONE NO.	_____
		DATE STARTED:	_____

5. FIELD OF EMPLOYMENT	☐ 1. HOSPITAL ☐ 2. NURSING HOME ☐ 3. SCHOOL OF NURSING ☐ 4. PRIVATE DUTY ☐ 5. HEAD NURSE OR ASSISTANT ☐ 6. SCHOOL HEALTH	☐ 7. OCCUPATION HEALTH ☐ 8. OFFICE/CLINIC NURSE (PHYSICIAN/DENTIST) ☐ 9. PRACTICAL NURSE PROGRAM ☐ 10. SELF-EMPLOYED OTHER THAN 4 ABOVE ☐ 11. OTHER (*SPECIFY*) _____
6. TYPE OF POSITION	☐ 1. ADMINISTRATOR OR ASSISTANT ☐ 2. CONSULTANT ☐ 3. SUPERVISOR OR ASSISTANT ☐ 4. INSTRUCTOR ☐ 5. HEAD NURSE OR ASSISTANT ☐ 6. STAFF OR GENERAL DUTY ☐ 7. NURSE PRACTITIONER (CERT. # _____)	☐ 8. CERTIFIED RN ANESTHETIST (CERT. # _____) ☐ 9. CERTIFIED NURSE MIDWIFE (CERT. # _____) ☐ 10. CLINICAL SPECIALIST ☐ 11. LICENSED PRACTICAL NURSE ☐ 12. OTHER (*SPECIFY*) _____
7. RACE/ETHNIC BACKGROUND	☐ 1. CHUUK STATE ☐ 2. KOSRAE STATE ☐ 3. POHNPEI STATE	☐ 4. YAP STATE ☐ 5. OTHER *(SPECIFY)* _____
8. MAJOR CLINICAL AREA	☐ 1. GERIATRIC ☐ 2. GYNECOLOGICAL/OBSTETRIC ☐ 3. MEDICAL/SURGICAL ☐ 4. PEDIATRIC ☐ 5. PSYCHIATRIC/MENTAL HEALTH	☐ 6. GENERAL PRACTICE ☐ 7. GENERALIZED COMMUNITY HEALTH (PUBLIC HEALTH) ☐ 8. OTHER *(SPECIFY)* _____
9. HIGHEST DEGREE	☐ 1. CERTIFICATE ☐ 2. DIPLOMA ☐ 3. ASSOCIATE DEGREE ☐ 4. BACCALAUREATE IN NURSING ☐ 5. BACCALAUREATE DEGREE	☐ 6. MASTER'S IN OTHER FIELD ☐ 7. MASTER'S IN NURSING ☐ 8. PH. D. ☐ 9. ED. D. ☐ 10. OTHER *(SPECIFY)* _____
10. BASIC EDUCATION PREPARATION	☐ 1. CERTIFICATE ☐ 2. DIPLOMA ☐ 3. ASSOCIATE DEGREE ☐ 4. BACCALAUREATE DEGREE ☐ 5. OTHER *(SPECIFY)* _____	GIVE LOCATION OF BASIC NURSING PROGRAM: _____ STATE OR FOREIGN COUNTRY _____ YEAR OF GRADUATION _____
11.REQUIREMENTS	A. INITIAL ☐ 1. PHOTOGRAPH ☐ 2. OFFICIAL TRANSCRIPT ☐ 3. COPY OF LICENSE ☐ 4. COPY OF DEGREE OR CERTIFICATE ☐ 5. NOTARIZE ☐ 6. OTHER *(SPECIFY)* _____	B. RENEWAL ☐ 1. CONTINUING EDUCATION ☐ 2. FEE STATES OTHER THAN FSM IN WHICH YOU ARE CURRENTLY LICENSED:_____

LEAVE BLANK FOR OFFICE USE ONLY:

CHECK: _____ MONEY ORDER _____ CASH _____

DATE RECEIVED: _____ ☐ ENTERED TICKLER CART

DATE PROCESSED: _____ ☐ ENTERED DATA PROCESSING

12. ARE YOU PRESENTLY IN GOOD PHYSICAL AND MENTAL HEALTH? IF NOT, GIVE PARTICULARS:

_____

13. HAVE YOU EVER BEEN VOLUNTARILY OR INVOLUNTARILY COMMITTED TO A PUBLIC OR PRIVATE MENTAL HEALTH FACILITY, DETOXIFICATION CENTER, OR CHEMICAL DEPENDENCY TREATMENT FACILITY OR BEEN DISABLED BY ACCIDENT OR PHYSICAL OR MENTAL ILLNESSES? IF SO, GIVE PARTICULARS:_____

14. DO YOU NOW OR HAVE YOU EVER, PERSONALLY USED OR ADMINISTERED TO YOURSELF ANY CONTROLLLED SUBSTANCES, OR HAVE YOU EVER BEEN TREATED FOR ALCOHOL OR DRUG ABUSE? IF SO, GIVE PARTICULARS AND DATES:

_____

15. HAVE YOU EVER BEEN THE SUBJECT OF INVESTIGATION BY ANY FEDERAL, STATE, OR LOCAL AGENCY HAVING JURISDICTION OVER CONTROLLED SUBSTANCES? IF SO, GIVE PARTICULARS:

_____

16. HAVE YOU EVER BEEN DENIED A LICENSE BY, OR THE PRIVILEGE OF TAKING AN EXAMINATION BEFORE ANY NURSING EXAMINATION BOARD, OR HAS A CONDITIONED LICENSE EVER BEEN ISSUED TO YOU BY ANY NURSING LICENSING BOARD? IF SO, GIVE PARTICULARS: _____

_____

17. HAS YOUR LICENSE TO PRACTICE NURSING IN ANY STATE OR COUNTRY EVER VOLUNTARILY OR INVOLUNTARILY (I.E., BY NURSING BOARD ORDER OR ANY OTHER FORM OF DISCIPLINARY ACTION) REVOKED, SUSPENDED, RESTRICTED OR CONDITIONED BY A NURSING BOARD? IF SO, GIVE PARTICULARS: _____

18. HAVE YOU EVER BEEN NOTIFIED OF ANY INVESTIGATIONS BY ANY STATE NURSING BOARD, NURSING SOCIETY, OR ANY HOSPITAL OF ANY COMPLAINTS AGAINST YOU RELATIVE TO THE PRACTICE OF NURSING, OR HAVE YOU EVER BEEN REPRIMANDED OR CENSURED BY ANY NURSING SOCIETY, OR LICENSING BOARD? IF SO, GIVE PARTICULARS: _____

_____

19. HAVE YOU EVER BEEN A DEFENDANT IN ANY MALPRACTICE LAWSUITS, HAD ANY MALPRACTICE SETTLEMENT OR HAVE ANY PENDING? IF SO, GIVE PARTICULARS: _____

_____

20. HAVE THERE EVER BEEN ANY CRIMINAL CHARGES FILED AGAINST YOU? IF SO, GIVE PARTICULARS:

_____

21. HAVE YOUR HOSPITAL PRIVILEGES EVER BEEN RESTRICTED OR REVOKED? IF SO, GIVE PARTICULARS: _____

Certificate of ethical and moral character (This certificate must be signed by two licensed practitioners who are personally acquainted with the applicant.)

Date: _____

I certify that the photograph attached is a recent one and likeness of Mr. / Ms. _____ and that he/she is a person of good ethical and moral character.

1. _____ _____
Name (printed) Signature

_____
Address

2. _____ _____
Name (printed) Signature

_____
Address

Affidavit of applicant:

State of: _____

Country of: _____

_____ being first duly sworn, says that he/she is the person referred to in the above application for license to practice nursing in the State of _____ and that statements herein contained are each and all strictly true in every respect.

_____
Applicant

Subscribed and sworn to before me this ____ day of _____, 20___.

_____
Clerk of Court