CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF NURSING

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@delaware.gov

APPLICATION FOR INDEPENDENT PRACTICE AS AN ADVANCED PRACTICE REGISTERED NURSE

INSTRUCTION SHEET

General Information

An Advanced Practice Registered Nurse (APRN) who is approved for independent practice is allowed to practice and prescribe

- outside the employment of an established health-care organization, health-care delivery system, physician, podiatrist, or practice group owned by a physician or podiatrist
- without a collaborative agreement

The independent practice must be in an area substantially related to the population and focus of the APRN's education and certification. See 24 *Del. C*. §1902 (k) and Section 8.17 in the Board's Rules and Regulations.

When to File Independent Practice Application

File this application when you are applying for independent practice ***and*** your APRN license simultaneously.

- You must file a separate application for each APRN role and population focus where you will be practicing independently.

- You must meet ***all*** of the following requirements for the role and population focus for which you are applying:
  - Practice as an APRN for at least two years with a collaborative agreement, ***and***
  - Practice as an APRN for at least 4,000 hours of clinical APRN practice with a collaborative agreement.

Requirements

☐ To verify the minimum experience requirement of two years and 4,000 hours of clinical APRN practice, attach the *Verification of Experience and Competency* form from each collaborator. Your collaborator(s) must complete, sign and **mail** the form directly to the Board office.

☐ Follow the instructions below for submission of this Independent Practice Application.

- To **upload** required documentation to your application:
  - **Visit** delpros.delaware.gov anytime…7 days a week…24 hours a day.
  - **Click** *Go* on the Apply/Manage a License and Service Requests.
  - **Log in** with your Email Address and Password**.**
  - **Select** the application on your e-License Dashboard.
  - **Click** *Options* on the application tile.
  - **Click** *Submit Additional Documentation*. Provide the reason then click **SAVE AND UPLOAD DOCUMENTS**.
  - **Click** *Upload* for each document required for your application.
  - **Click** *Submit* to finish the request.

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APPLICATION NUMBER: APP - _____

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____ _____
   Last First Middle Maiden

2. Other Names Used: None ☐ _____ _____ _____

3. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter SSN:** _____

4. Mailing Address: _____

   _____ _____ _____
   City State Zip

5. Phone: _____ _____
   daytime evening or cell

EXPERIENCE

6. Select the APRN specialty in which you wish to practice independently. Check only **one** role:

   ☐ Certified Registered Nurse Anesthetist (CRNA)

   ☐ Certified Nurse Midwife

   ☐ Certified Nurse Practitioner (NP) – Check ***one*** population focus area in this role:
   ☐ Adult/Gerontological ☐ Family ☐ Neonatal ☐ Pediatric
   ☐ Psychiatric/Mental Health ☐ Women's Health/Gender-Related

   ☐ Clinical Nurse Specialist (CNS) – Check ***one*** population focus area in this role:
   ☐ Adult/Gerontological ☐ Family ☐ Neonatal ☐ Pediatric
   ☐ Psychiatric/Mental Health ☐ Women's Health/Gender-Related

7. I certify that I have completed two years **and** 4,000 hours of clinical APRN practice in this role? Yes ☐

   Arrange for each collaborator to complete the *Verification of Experience and Competency* form.

8. Enter the following information about the person(s) who will be submitting verification of your clinical APRN practice experience. If you need more room, enclose a separate sheet with the same information.

COLLABORATOR	ADDRESS	PHONE	EMAIL

CERTIFICATION

I declare and affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

***Signature of Applicant*: _____ Date: _____**

Follow the instructions below for submission of this Independent Practice Application.

- To **upload** required documentation to your application:
  - **Visit** delpros.delaware.gov anytime…7 days a week…24 hours a day.
  - **Click** *Go* on the Apply/Manage a License and Service Requests.
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VERIFICATION OF EXPERIENCE AND COMPETENCY

INSTRUCTIONS

The purpose of this form is to verify the experience and competency of an Advanced Practice Registered Nurse (APRN) who is seeking independent practice in Delaware. The collaborator must review the entire form, sign it and mail it ***directly*** to the Board of Nursing at the address above. Forms not received *directly* from the collaborator will not be accepted.

1. APRN Name: _____ Application Number: APP - _____

2. Collaborator Name: _____

3. Business/Practice Name: _____

4. Location Address: _____
(If more than one location, enter main location. *No PO Box!)*

5. Collaborator Phone: _____ Collaborator Email: _____

6. Provide the following information about **your** professional licensure:

☐ Physician ☐ Podiatrist ☐ Other: _____

License Number: _____ Specialty: _____

7. Select the business/practice that best describes where the collaborative agreement with the APRN listed above took place (check all that apply):

☐ Healthcare organization ☐ Licensed healthcare delivery system ☐ Physician, podiatrist, or practice group

8. Your area of practice while you were the APRN's collaborator must be substantially related to the APRN's education, certification and planned independent practice. Check the APRN role for which you served as collaborator:

☐ Certified Registered Nurse Anesthetist (CRNA)

☐ Certified Nurse Midwife

☐ Certified Nurse Practitioner (NP) – Check ***one*** population focus area in this role:
☐ Adult/Gerontological ☐ Family ☐ Neonatal ☐ Pediatric
☐ Psychiatric/Mental Health ☐ Women's Health/Gender-Related

☐ Clinical Nurse Specialist (CNS) – Check ***one*** population focus area in this role:
☐ Adult/Gerontological ☐ Family ☐ Neonatal ☐ Pediatric
☐ Psychiatric/Mental Health ☐ Women's Health/Gender-Related

9. To practice independently in Delaware, an APRN is required to complete at least two years ***and*** at least 4,000 hours of clinical APRN practice. ***Enter the following information about the period when you were the APRN's collaborator***.

Total hours of APRN clinical practice: _____

Time period during which the APRN practiced: From _____ (Month/Year) To _____ (Month/Year)

10. I verify the APRN is competent and has met all requirements for Independent Practice: ☐ Yes ☐ No

CERTIFICATION

I affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

***Collaborator Signature*:**_____ Date: _____

MAIL THIS FORM DIRECTLY TO THE BOARD OFFICE AT THE ADDRESS ABOVE

Revised 06/2020