



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](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

## APPLICATION FOR LICENSURE AS A REGISTERED OR PRACTICAL NURSE BY ENDORSEMENT INSTRUCTION SHEET

Follow instructions carefully.  
You must answer *all* questions unless the instruction says to skip them.  
Do not leave answers blank if the instruction says to enter them. If an answer is "none," enter *None*.  
*Incomplete applications will be rejected.*

### When to File Endorsement Application: Licensure Requirement

Complete this application if you hold an active Nursing license **or** have ever held a Nursing license of the same type in another jurisdiction (state, U.S. territory or District of Columbia) **and** you have never held a Delaware Nursing license of the same type.

- If you have ever held a Delaware license of the same type, complete the [Application for Reinstatement of RN or LPN License](#) instead.
- If you have **never** held a license of the same type in another jurisdiction **or** a Delaware RN/LPN license **and** you have passed the NCLEX examination, you must complete the [Application for Licensure as a Registered or Licensed Practical Nurse by Examination](#).

### When to File Endorsement Application: Home State of Residence Requirement

Your *home state of residence* (also called the primary state of residence) is your declared fixed, permanent and principal home for legal purposes. Complete this application **only if one of the following applies to you**:

- Your current home state of residence is Delaware, **OR**
- Your current home state of residence is **not** an [Enhanced Nurse Licensure Compact \(eNLC\)](#) state, **OR**
- Your current home state of residence is another [eNLC state](#) but you plan to move to Delaware or to a state that is **not** an eNLC state, **OR**
- Your current home state of residence is another [eNLC state](#) but your license from your home state is **not** a Multistate license.

### When to File Endorsement Application: Practice Requirement

To be licensed by endorsement Delaware, you must meet one of the following practice requirements. If possible, you must complete one of these requirements **before filing this application**:

- Graduation from a Nursing education program within the past two years (24 months)
  - The program must be a State Board of Nursing approved Registered Nurse or Practical Nursing education program. Section 2.4.1.7.4 of the Board's [Rules and Regulations](#) requires *at least* 200 hours of clinical experience for LPN students and *at least* 400 hours of clinical experience for RN students.
- At least 1000 hours of nursing practice during the five years (60 months) before filing this application.
- At least 400 hours of nursing practice during the two years (24 months) before filing this application.
- Completion of a Board-approved refresher program
  - Section 3.0 in the Board's [Rules and Regulations](#) explains the requirements for refresher programs.
  - See also [Approved Delaware Nursing Education & Refresher Programs](#) on the Board's website.

If it is *not possible* to meet any of the above practice requirements, you may file this application and request the Board's approval of an alternate supervised practice plan. Your application will be processed and a temporary permit will be issued while working under a supervised practice plan, see [RN/LPN Temporary Permit](#) for instructions on applying. For information about supervised practice plans, see Section 4.0 of the Board's [Rules and Regulations](#).

### Requirements for *All* Applicants by Endorsement

- Submit completed, signed and notarized [Application for Licensure as a Registered or Licensed Practical Nurse by Endorsement](#).
  - **Follow instructions carefully. You must answer *all* questions unless the instruction says to skip them. Do not leave answers blank if the instruction says to enter them. If an answer is "none," enter *None*. Incomplete applications will be rejected.**
  - Read the AFFIDAVIT section and sign the application in front of a notary public. Forms that are unsigned or not notarized will be rejected.
  
- Enclose the non-refundable [processing fee](#) by check or money order made payable to "State of Delaware."
  - Applications submitted without this processing fee will be rejected.
  
- Enclose a copy of your driver's license or official identification card from the Division of Motor Vehicles.
  - The state (or other jurisdiction) on the identification you provide is considered your home state of residence.
  - If you don't have a driver's license or official identification from the Division of Motor Vehicles, you may submit a voter registration card, federal tax return, military form 2058 or a Form W-2 showing your home state of residence.
  
- Enclose a photocopy of your nursing license from another jurisdiction **or** you may send a printout of your state's online verification.
  - If there is a signature section on your license, sign it before copying.
  - If the jurisdiction where you are currently licensed is a compact state, you can work in Delaware with your current compact state license until your Delaware license is issued.
  
- Complete the *Authorization for Release of Information* form to request a State of Delaware and Federal Bureau of Investigation criminal background check. Follow the instructions on the authorization form to arrange to be fingerprinted.**
  - You must complete this requirement *even if* you recently had a criminal background check done for some other reason.
  - Information or details on the State and Federal background report will be reviewed to determine whether you must submit any additional information or documents as part of the application process.
  
- Arrange for the Board office to receive *Nursing Employer Reference Form(s)* **or** a *Nursing School Reference Form* as follows:
  - If you have been employed *as the same type of nurse for which you are applying* for at least the past six months, send a *Nursing Employer Reference* form to *each* nursing employer where you worked during the past six months.
  - If you have **not** been employed *as the same type of nurse for which you are applying* for at least the past six months **but** you graduated from your nursing program within the past two years (24 months), send the *Nursing School Reference* form to your nursing school for completion.
  - If you have **not** been employed for at least the past six months and you did not graduate from nursing school within the past two years (24 months) **but** you were employed *as the same type of nurse for which you are now applying* within the past five years (60 months), send a *Nursing Employer Reference* form to your most recent nursing employer(s) where you worked for at least six months.
  - After completing the form, the employer(s) (or nursing school) must return the form by mail *directly* to the Board office. Forms received from you will be rejected.

- Provide verification of original licensure by examination. *How you do this depends on whether the jurisdiction where you were licensed uses the NURSYS™ databank.* Jurisdictions that use NURSYS™ are:

Alaska, Alabama, American Samoa, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana-Registered Nurse, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Northern Mariana Islands, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virgin Islands, Virginia, Washington, West Virginia, Wisconsin, Wyoming

- If your original jurisdiction of licensure is listed above, go to <https://www.nursys.com/> and complete the NURSYS™ Verification Request.
- If your original jurisdiction of licensure is **not** listed above, complete the *Verification of Original Licensure* form and send it to the Board of Nursing **in the jurisdiction where you were licensed by examination.** Contact that jurisdiction to find out if there is a fee.

- If you received your Nursing education outside the U.S. (including Canada) or in Puerto Rico, request a CES report **or** a Certificate verification letter from [CGFNS](#). You must call CGFNS customer service to order your verification. The verification must be sent to us *directly* from CGFNS.

- If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).

*The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

### **Temporary Permit for RN or LPN**

For information on applying for a temporary permit, see [RN/LPN Temporary Permit](#). *Carefully read the instructions about when you may apply.* **Do not begin orientation or employment until you are assigned a temporary permit number.**



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

STATE OF DELAWARE  
**BOARD OF NURSING**

|                        |             |
|------------------------|-------------|
| <b>OFFICE USE ONLY</b> |             |
| DDB                    | _____       |
| R. V. T. CBC CE        | _____       |
| CCL EXPIRES            | _____       |
| Nursys Verification?   | _____       |
| ID                     | _____ CGFNS |

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: [DPR.DELAWARE.GOV](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

## APPLICATION FOR LICENSURE AS A REGISTERED OR PRACTICAL NURSE BY ENDORSEMENT

Follow instructions carefully.  
You must answer *all* questions unless the instruction says to skip them.  
Do not leave answers blank if the instruction says to enter them. If an answer is "none," enter *None*.  
*Incomplete applications will be rejected.*

### TYPE OF APPLICATION

1. Check type of application you are filing:

- Registered Nurse – I have an active **or** inactive RN license in another jurisdiction (state, U.S. territory or District of Columbia) **and** have *never* held a Delaware RN license.
- Licensed Practical Nurse – I hold an active **or** inactive LPN license in another jurisdiction (state, U.S. territory or District of Columbia) **and** have *never* held a Delaware LPN license.

**Enclose a photocopy of your nursing license from another jurisdiction or a printout of the online verification.**

### IDENTIFYING AND CONTACT INFORMATION

2. Full Name: \_\_\_\_\_  
Last First Middle Maiden

3. Other Names Used: None  \_\_\_\_\_

4. Date of Birth (month/day/year): \_\_\_\_\_ Gender: Male  Female

5. Have you been issued a U.S. Social Security Number? Yes  No  If yes, enter your SSN: \_\_\_\_\_  
**If no, you must file a [Request for Exemption from Social Security Number Requirement](#).**

6. Your *home state of residence* (also called the primary state of residence) is your declared fixed, permanent and principal home for legal purposes. Enter your *Home State (or jurisdiction) of Residence*: \_\_\_\_\_

**Enclose a copy of your driver's license or an identification card issued by the Division of Motor Vehicles showing this state or jurisdiction as your legal residence. See the Instruction Sheet if you have neither of these types of identification.**

7. Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

8. Phone: \_\_\_\_\_ daytime \_\_\_\_\_ evening or cell Email: \_\_\_\_\_

## EDUCATION INFORMATION

9. Enter the following information about the **high school** you attended:

High School Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip/Postal Code

Year Entered: \_\_\_\_\_ Year Completed (check one):  I graduated from high school. Enter year: \_\_\_\_\_

I received a GED. Enter year: \_\_\_\_\_

10. Did you graduate from a nurse education program *outside* the United States (including Canada) **or** Puerto Rico?

Yes  No  If yes, enter CGFNS Number: \_\_\_\_\_ Certificate Date: \_\_\_\_\_

**Request a CES report or a Certificate verification letter from [CGFNS](#) to be sent *directly* to the Board office.**

11. If you are now applying for an RN license, enter the following information about the **first** RN program you completed. If you are now applying for an LPN license, enter the information about the **first** PN program you completed:

Name of Institution Conducting Nursing Program: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip/Postal Code

Entered Program Month/Year: \_\_\_\_\_ Graduated Month/Year: \_\_\_\_\_

Type of Program (check one):  Baccalaureate  Associate  Registered Nurse Diploma

Practical Nurse Diploma  Practical Nurse Certificate

Other – Enter type of degree: \_\_\_\_\_

## EXAM & LICENSURE HISTORY – In these questions, jurisdiction means state, District of Columbia, U.S. territory.

12. Have you ever applied to take an examination for RN or LPN licensure but were *denied*? Yes  No

**If yes, enter the jurisdiction(s):** \_\_\_\_\_ **Explain why you were denied:**

\_\_\_\_\_  
\_\_\_\_\_

13. Have you ever taken an examination for RN or LPN licensure and *failed*? Yes  No

**If yes, enter the jurisdiction(s):** \_\_\_\_\_ **Date:** \_\_\_\_\_

14. Enter the information about where you were **originally** licensed by *examination*:

Jurisdiction: \_\_\_\_\_ License Number: \_\_\_\_\_ Year Issued: \_\_\_\_\_

**Provide verification of original licensure by examination. *How you do this depends on whether the jurisdiction where you were licensed uses the NURSYS™ databank. See the Instruction Sheet.***

## NURSING PRACTICE

15. Did you graduate from a Nursing education program within the past **two** years (24 months)? Yes  No

• **If no, continue to the next question.**

• **If yes, enter the following information about the school and SKIP to the DISCLOSURES section:**

School Name: \_\_\_\_\_ Graduation Date: \_\_\_\_\_

**Arrange for the Board office to receive a *Nursing Reference Form* directly from your nursing school.**

16. Have you practiced *at least 1000* hours during the past *five* years (60 months) **or** *at least 400* hours during the past *two* years in any jurisdiction (state, U.S. Territory or District of Columbia) where you have **ever** held a nursing license? Yes  No
- If no, **SKIP to question 17.**
  - If yes, **complete the following about your *Nursing* employment. SKIP to the CONTINUING EDUCATION section.** (If you need more room, enclose additional sheets.)

| RN or LPN?  | EMPLOYER NAME AND EMAIL ADDRESS | ADDRESS (city, state) | EMPLOYMENT DATES |    | TOTAL HOURS PER WEEK |
|---|---------------------------------|-----------------------|------------------|----|----------------------|
|   |                                 |                       | From             | To |                      |
| <input type="checkbox"/> RN<br><input type="checkbox"/> LPN |                                 |                       |                  |    |                      |
| <input type="checkbox"/> RN<br><input type="checkbox"/> LPN |                                 |                       |                  |    |                      |
| <input type="checkbox"/> RN<br><input type="checkbox"/> LPN |                                 |                       |                  |    |                      |
| <input type="checkbox"/> RN<br><input type="checkbox"/> LPN |                                 |                       |                  |    |                      |

**Arrange for the Board office to receive a *Nursing Reference Form* from each employer listed above, sent *directly* to the Board office.**

17. Have you completed a Delaware Board-approved nursing refresher course in the past **two** years? Yes  No  **If yes, SKIP to the DISCLOSURES section. If no, continue to question 18.**

**Submit a copy of the refresher course completion certificate.**

18. Check the situation that applies to you. **SKIP to the DISCLOSURES section:**

- I plan to complete a Board-approved nursing refresher course.
- I am requesting an alternate supervised practice plan.

**CONTINUING EDUCATION – See Section 9.0 in the Board’s [Rules and Regulations](#).**

19. Check the situation that applies to you:

- I am an LPN **and** have completed *at least 24 hours* of continuing education (CE) in the past **two** years.
- I am an RN **and** have completed *at least 30 hours* of continuing education (CE) in the past **two** years.

20. List the CE you have completed in the past **two** years in the spaces provided below.

- Enter complete date (month/day/year) as shown on certificate.
- Enter complete course names and names of providers (not the presenters).
- Enter the number of CE hours for each course and provide a total.
- If you need more room, provide the same information on a separate sheet and enclose it with the application.

| COURSE DATE  | NAME OF COURSE/PROGRAM/CONFERENCE | PROVIDER NAME | CE HOURS |
|--------------|-----------------------------------|---------------|----------|
|              |                                   |               |          |
|              |                                   |               |          |
|              |                                   |               |          |
|              |                                   |               |          |
|              |                                   |               |          |
|              |                                   |               |          |
|              |                                   |               |          |
| <b>TOTAL</b> |                                   |               |          |

## DISCLOSURES

Complete the Criminal History Record Check Authorization form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

21. Have you received any administrative penalties regarding your practice of nursing in any jurisdiction, including but not limited to the following.
- Fines? Yes  No
  - Formal reprimands? Yes  No
  - License suspensions? Yes  No
  - License revocations (except for non-payment of fees)? Yes  No
  - Probationary limitations? Yes  No
  - Other? Yes  No  If yes, what kind of penalty: \_\_\_\_\_
- If yes, submit a letter of explanation and all relevant legal documentation.**
22. Is any complaint or disciplinary action pending against your license in any other jurisdiction? Yes  No   
**If yes, submit a letter of explanation and all relevant legal documentation.**
23. Has your application for a license ever been refused or denied in any other jurisdiction? Yes  No   
**If yes, submit a letter of explanation and all relevant legal documentation.**
24. Have you entered into any consent agreements containing conditions that a licensing board has placed on your professional conduct and practice? Yes  No   
**If yes, submit a letter of explanation and all relevant legal documentation.**
25. Do you have any impairment related to drugs or alcohol that would limit your practice of nursing?  
Yes  No  **If yes, submit a letter of explanation and all relevant legal documentation.**

## DUTY TO REPORT

26. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 Del. C. §1731 OR that he/she is (or may be):
- medically incompetent
  - mentally or physically unable to engage safely in the practice of medicine
  - excessively using or abusing drugs including alcohol.
- I certify that I have read the provisions of [24 Del. C. §1730](#), [24 Del. C. §1731](#) and [24 Del. C. §1731A](#) and I understand my *duty to report*. Yes  No
27. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.
- I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes  No
28. To obtain a license in Delaware, you must certify that you understand that you have a mandatory duty to report any unsafe nursing practice to the Board of Nursing and to report any unsafe practice conditions to the recognized legal authorities.
- I certify that I have read and understand [Section 7.3.1.6](#) of the Board of Nursing's Rules and Regulations and that I understand my *duty to report*. Yes  No
29. To obtain a license in Delaware, you must certify that you understand that you have a mandatory duty to self report all of the following to the Board within 30 days:
- Arrest or indictment for, or information charging you with, a crime substantially related to the practice of nursing as defined in Section 15.0 of the Board's Rules and Regulations
  - Conviction, including any verdict of guilty or plea of guilty or no contest, for any crime substantially related to the practice of nursing as defined in Section 15.0 of the Board's Rules and Regulations.
- I certify that I have read and understand all provisions of the Delaware Nursing Practice Act, including [24 Del. C. §1930A](#), and the [Rules and Regulations](#), and that I understand my *duty to self report*. Yes  No

**Continued on next page**

If Board review of your application is required, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date in order to ensure consideration of your application at the meeting:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within 12 months of filing may be considered abandoned and discarded.

### AFFIDAVIT

The law regulating the practice of Nursing in Delaware, 24 Del. C. §1922 (a), "Grounds for Discipline," provides that the Board of Nursing may revoke or suspend any license to practice nursing, refuse a license or re-licensing or otherwise discipline a licensee upon proof that a licensee or former licensee is guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing.

The applicant, being duly sworn, says that he/she is the person referred to in the foregoing application for licensure as registered/licensed practical nurse in the State of Delaware, that he/she meets the requirements for licensure, that the statements therein contained are true and that he/she has read and understands this affidavit.

**APPLICANT SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_\_

County of \_\_\_\_\_ State of \_\_\_\_\_

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_ 2 \_\_\_\_\_,

Notary Public: \_\_\_\_\_

SEAL

My commission expires: \_\_\_\_\_

***APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED PROCESSING FEE WILL BE REJECTED.***



# Instructions for Requesting a Criminal Background Check

**Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.**

## Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See [Title 28, CFR 16.34](#) for the procedure to obtain a change, correction or update in the FBI record.

## Locations

### **Kent County – Primary Facility**

State Bureau of Identification  
Blue Hen Mall & Corporate Center  
655 S. Bay Rd. Suite 1B  
Dover, DE 19901

**Walk-ins accepted:** Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm  
Customer Service: (302) 739-2134

### **New Castle County - Satellite Facility**

State Police Troop Two  
100 LaGrange Ave  
Newark, DE 19702  
(between Rts. 72 and 896 on Rt. 40)

**By appointment only**

Scheduling: (302) 739-2528 (local)  
(800) 464-4357 (toll free)

### **Sussex County – Satellite Facility**

Thurman Adams State Service Center  
546 S. Bedford Street, Rm. 202  
Georgetown DE 19947  
(across from DelDOT & Troop 4)

**By appointment only**

Scheduling: (302) 739-2528 (local)  
(800) 464-4357 (toll free)

## Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. **Personal checks are not accepted in any county.** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

## Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a [FD-258 fingerprint form](#) available on the FBI website at [www.fbi.gov](http://www.fbi.gov) – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.
2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.
3. **Mail** the *Authorization* form, fingerprint card, and *certified* check or money order (**personal checks are not accepted**) for \$65.00 made payable to “Delaware State Police” to:

**Delaware State Police  
State Bureau of Identification (SBI)  
PO Box 430  
Dover, DE 19903-0430**

**DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.  
DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.  
⇒ ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.**



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

STATE OF DELAWARE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: [DPR.DELAWARE.GOV](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

### AUTHORIZATION FOR RELEASE OF INFORMATION

#### CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

*Please print or type all information in black ink.*

**Check the type of license for which you are applying:**

- Adult Entertainment
- Charitable Gaming Vendor
- Chiropractic
- Dental
- Funeral
- Massage
- Medical (Physicians (MD, DO and Administrative Medical), Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- Mental Health (LPCMH, LCDP, LMFT, LACMH, LAMFT, LPAT, LAAT)
- Nursing (RN, LPN, APRN)
- Nursing Home Administrator
- Occupational Therapy
- Optometry
- Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- Physical Therapy/Athletic Trainer
- Podiatry
- Psychology
- Real Estate Appraiser (includes Appraisal Management Company)
- Speech/Hearing
- Social Work
- Texas Hold'em Individual

**Print your current full name:**

\_\_\_\_\_

Last Name
First Name
Middle Initial
Suffix (e.g., Jr., Sr.)

**Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

**SIGNATURE OF PERSON PRINTED:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

**Mail the results of my criminal history request to:**

**Division of Professional Regulation  
861 Silver Lake Boulevard, Suite 203  
Dover DE 19904  
SLC D420A**

**USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.**

## NONCRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for a job or license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification<sup>1</sup> that your fingerprints will be used to check the criminal history records of the FBI.
- If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job, license, or other benefit based on information in the criminal history record.<sup>2</sup>

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.<sup>3</sup>

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at <http://www.fbi.gov/about-us/cjis/background-checks>.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

---

<sup>1</sup> Written notification includes electronic notification, but excludes oral notification.

<sup>2</sup> See 28 CFR 50.12(b).

<sup>3</sup> See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).



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

STATE OF DELAWARE  
**BOARD OF NURSING**

TELEPHONE: (302) 744-4500  
WEBSITE: [DPR.DELAWARE.GOV](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

## NURSING SCHOOL REFERENCE FORM

### INSTRUCTIONS

#### Application by Examination

Complete this form when applying for nursing licensure by examination.

#### AUTHORIZATION FOR RELEASE OF INFORMATION

As an applicant for Nursing licensure in the State of Delaware, I hereby authorize release of reference information about my Nursing education at the institution named below.

**APPLICANT SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_\_

#### APPLICANT INFORMATION – To be completed by applicant

1. Type of Application:  RN  LPN  APRN
2. Applicant Name: \_\_\_\_\_  
Last First Middle
3. Address: \_\_\_\_\_  
Street City State Zip
4. Social Security Number: \_\_\_\_\_
5. Phone: \_\_\_\_\_ Email: \_\_\_\_\_
6. School Name: \_\_\_\_\_
7. School Address \_\_\_\_\_  
Street City State Zip

#### REFERENCE – To be completed by the Nursing School

8. Name of School \_\_\_\_\_
9. Applicant's Graduation Date (mm/dd/yy): \_\_\_\_\_ Degree Awarded: \_\_\_\_\_
10. Which program did the applicant complete?  RN Program  LPN Program
  - RN Program: Did the program provide *at least 400* hours of clinical experience? Yes  No
  - LPN Program: Did the program provide *at least 200* hours of clinical experience? Yes  No
11. Printed Name of School Representative: \_\_\_\_\_
12. Title of School Representative: \_\_\_\_\_
13. Signature of School Representative: \_\_\_\_\_
14. Phone: \_\_\_\_\_ Email: \_\_\_\_\_

***The Board office will accept only forms it receives directly from the school.***

**FAXED FORMS WILL NOT BE ACCEPTED.**



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

STATE OF DELAWARE  
**BOARD OF NURSING**

TELEPHONE: (302) 744-4500  
WEBSITE: [DPR.DELAWARE.GOV](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

## NURSING EMPLOYER REFERENCE FORM

### INSTRUCTIONS

#### Application by Endorsement or Reinstatement

When applying for nursing licensure by endorsement or reinstatement, arrange for the Board office to receive this form when any of the following situations apply:

- You have been employed as *the same type of nurse for which you are applying* for at least the past six months.
- You have **not** been employed as *the same type of nurse for which you are applying* for at least the past six months **but** you graduated from your nursing program within the past two years (24 months), complete the [Nursing School Reference Form](#).
- You have **not** been employed for at least the past six months **and** you did **not** graduate from nursing school within the past two years **but** you were employed as *the same type of nurse for which you are applying* within the past five years.

### AUTHORIZATION FOR RELEASE OF INFORMATION

As an applicant for Nursing licensure in the State of Delaware, I hereby authorize release of reference information about my Nursing employment at the facility named below.

**APPLICANT SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_\_

#### APPLICANT INFORMATION – To be completed by applicant

4. Type of Application:  RN  LPN  APRN

5. Applicant Name: \_\_\_\_\_  
Last First Middle

6. Address: \_\_\_\_\_  
Street City State Zip

6. Social Security Number: \_\_\_\_\_

7. Phone: \_\_\_\_\_ Email: \_\_\_\_\_

15. Employer Name: \_\_\_\_\_

16. Employer Address \_\_\_\_\_  
Street City State Zip

#### REFERENCE – To be completed by the Nursing Employer

17. Applicant is/was employed as an: LPN  RN  APRN  Applicant is **currently** employed Yes  No

18. Full Time:  Part Time:  Average Number of Hours Worked Per Week: \_\_\_\_\_

19. Based on applicant's performance, would you recommend him or her for licensure? Yes  No  **If no, provide an explanation:** \_\_\_\_\_  
\_\_\_\_\_

20. Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Printed name of person completing form: \_\_\_\_\_ Date: \_\_\_\_\_

21. Phone: \_\_\_\_\_ Email: \_\_\_\_\_

***The Board office will accept only forms it receives directly from the school.***

**FAXED FORMS WILL NOT BE ACCEPTED**



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](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

## VERIFICATION OF ORIGINAL LICENSURE

### SECTION A: APPLICANT INFORMATION – to be completed by applicant

Use this form only if the state or other jurisdiction where you were originally licensed by examination is **not** listed below. If your original jurisdiction **is** listed below, go to <https://www.nursys.com/> and submit the *Nursys Verification Request*.

Alaska, Alabama, American Samoa, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana-Registered Nurse, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Northern Mariana Islands, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virgin Islands, Virginia, Washington, West Virginia, Wisconsin, Wyoming

Mail form to jurisdiction where you were originally licensed by examination. Find out if the jurisdiction requires a fee before mailing.

1. State/Jurisdiction Where Originally Licensed: \_\_\_\_\_ 2. License Number: \_\_\_\_\_

3. Name: \_\_\_\_\_  
Last First Middle

*If originally licensed under another name, enclose copy of legal document showing name change.*

4. Address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip

5. Social Security Number: \_\_\_\_\_

### SECTION B: ORIGINAL LICENSURE VERIFICATION – to be completed by Board of Nursing in jurisdiction of original licensure – return to Delaware Board of Nursing at address above

Name of Nursing School: \_\_\_\_\_ Board-Approved? Yes  No

Location: \_\_\_\_\_ Year Graduated: \_\_\_\_\_

Program: AD  BSN  Diploma  PN  High School Graduate or GED? Yes  No

NCLEX/CAT: Series: \_\_\_\_\_ Date: \_\_\_\_\_ Pass: \_\_\_\_\_

SBTPE Series: \_\_\_\_\_ Date: \_\_\_\_\_ Med: \_\_\_\_\_ OB: \_\_\_\_\_ Surg: \_\_\_\_\_ Peds: \_\_\_\_\_ PSV: \_\_\_\_\_

Date of Original Licensure: \_\_\_\_\_ License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Currently licensed? Yes  No

Has license ever been disciplined? Yes  No  If yes, enclose copy of "decision & order" for each action.

*I certify that the statements contained herein are true to the best of my knowledge.*

**Board Representative Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Board of Nursing of \_\_\_\_\_

BOARD SEAL