

3. Applicant's Contact Information:

Address Line 1

Address Line 2

City, State, Zip

Daytime Phone Number

Alternate Phone Number

E-mail Address

4. Applicant's Employer: _____

Employer's Contact Information:

Name

Address Line 1

Address Line 2

City, State, Zip

Title

Daytime Phone Number

Fax Number

E-mail Address (if available)

5. Specify the name and location of the LVN/LPN or PT school from which you graduated.

Name

Location

6. Did you pass a LVN/LPN or PT licensure examination? Yes No

Name of Examination

Date of Examination

PART B – LICENSURE INFORMATION

1. Do you hold a current valid and active license, certification, or registration issued by a state, district, or territory of the United States authorizing the unrestricted practice of LVN/LPN services or providing PT services in your jurisdiction(s)? Yes No

- A. If no, you are not eligible to participate as an out-of-state practitioner in the sponsored event.
- B. If yes, list every license, certificate, and registration authorizing you to engage in the practice of LVN/LPN or providing PT services in the following table. If there are not enough boxes to include all the relevant information please attach an addendum to this form. **Please also attach a copy of each of your current licenses, certificates, and registrations.**

State/ Jurisdiction	Issuing Agency/Authority	License Number	Expiration Date

2. Have you ever had your LVN/LPN or PT license or certification to practice revoked or suspended?
___ Yes ___ No

3. Have you ever been subject to any disciplinary action or proceeding by a licensing body?
___ Yes ___ No

4. If you answered "Yes" to question 2 and/or 3, please explain (*attach additional page(s) if necessary*):

PART C – SPONSORED EVENT

1. Name and address of local government entity or non-profit or community-based organization (the "sponsoring entity") hosting the free healthcare event: _____

2. Name of event: _____

3. Date(s) & location(s) of the event: _____

4. Date(s) & location(s) applicant will be performing healthcare services (if different):

5. Please specify the healthcare services you intend to provide: _____

6. Name and phone number of contact person with sponsoring entity or local government entity: _____

PART D – ACKNOWLEDGMENT & CERTIFICATION

I, the undersigned, acknowledge and declare under penalty of perjury under the laws of the State of California that:

- I have not committed any act or been convicted of a crime constituting grounds for denial of licensure by the Board.
- I am in good standing with the licensing authority or authorities of all jurisdictions in which I hold licensure and/or certification to practice LVN/LPN or provide PT services.
- I will comply with all applicable practice requirements required of LVNs/LPNs or licensed PTs and all regulations of the Board.
- In accordance with B&P Code Section 901(i), I will only practice within the scope of my licensure and/or certification and within the scope of practice for California LVNs/LPNs or PTs.

- I will provide the services authorized by this request and B&P Code Section 901 to uninsured and underinsured persons only and shall receive no compensation for such services.
- I will provide the services authorized by this request and B&P Code Section 901 only in association with the sponsoring entity or local government entity listed herein and only on the dates and at the locations listed herein **for a period not to exceed ten (10) calendar days**.
- I am responsible for knowing and complying with California law and practice standards while participating in a sponsored event located in California.
- I understand that practice of a regulated profession in California without proper licensure and/or authorization may subject me to potential administrative, civil and/or criminal penalties.
- I understand that the Board may notify the licensing authority of my home jurisdiction and/or other appropriate law enforcement authorities of any potential grounds for discipline associated with my participation in the sponsored event.
- All information provided by me in this application is true and complete to the best of my knowledge. By submitting this application and signing below, I am granting permission to the Board to verify the information provided and to perform any investigation pertaining to the information I have provided as the Board deems necessary.

Signature

Date

Name Printed

License No.

GENERAL APPLICATION INSTRUCTIONS & MAILING REQUIREMENTS
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This "Request for Authorization" must be completed in full and must be accompanied by all of the following:

- **Fee** – Attach a check for fifty dollars (\$50) made payable to the "BVNPT." This is a non-refundable fee that covers the processing of your request.
- **Photo Identification** – A copy of a valid photo identification of the applicant issued by one of the jurisdictions in which the applicant holds a license or certificate to practice.
- **Copy of License(s)** – A copy of the applicant's current LVN/LPN or PT license from all applicable states/jurisdictions of the U.S.
- **Verification of Licensure** – The Board requires a Verification of Licensure from the State Licensing Authority through which the applicant was originally licensed. If the applicant's original license has expired, the applicant must also submit a Verification of Licensure from the state in which he/she holds a current license.

- **Fingerprints** – The Board requires a California DOJ and Federal Bureau of Investigation (FBI) criminal history background check on all applicants. Therefore, each applicant must follow the enclosed instructions on the fingerprint process. The applicant will be required to either: (1) Submit two (2) fingerprint cards and a fee of fifty-one dollars (\$51) made payable to the “BVNPT”; or (2) Complete and submit a “Request for Live Scan Service” at an approved Live Scan site. The applicant will be required to pay the applicable Live Scan service fee and a rolling fee directly to the Live Scan Service Provider. The request for authorization cannot be granted until the Board receives a clearance report from the DOJ. (Note: Upon receipt of both a DOJ and FBI clearance report, the applicant need not submit his/her fingerprint records again for four (4) years from the last request for authorization.)
- **Mailing Address** – Please mail the request, fees, and all applicable documents to:

**BVNPT
2535 Capitol Oaks Drive, Suite 205
Sacramento, CA 95833**

Social Security Number – B&P Code Section 30 and Public Law 94-455 [(42 USCA 405 (c)(2)(C)] authorizes collection of your social security number. Applications for licensure will not be processed until a valid U.S. Social Security Number is received.

Privacy Act – The Department of Consumer Affairs collects the personal information requested on this form as authorized by B&P Code Section 30 (General Provisions); B&P Code Section 901; B&P Code Division 2, Chapter 6.5 (Vocational Nursing Practice Act) and Chapter 10 (Psychiatric Technician Law); and California Code of Regulations Title 16, Division 25, Chapter 1 (Vocational Nurses) and Chapter 2 (Psychiatric Technicians).