



INSTRUCTIONS TO APPLICANTS FOR LICENSURE AS A LICENSED VOCATIONAL NURSE

Notice to Individuals (Civ. Code, Sec. 1798.17) -- ALL items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information requested will be used to determine qualifications for examination and/or registration under the Vocational Nursing Practice Act. The official responsible for information maintenance is the Executive Officer at the above noted address and telephone number. The information may be transferred to another governmental agency, such as a law enforcement agency, if necessary, for the agency to perform its duties. Individuals have the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by Section 1798.40 of the Civil Code.

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY WHEN COMPLETING YOUR APPLICATION:

STEP #1

APPLICATION FOR VOCATIONAL NURSE EXAMINATION AND LICENSURE--To apply for the Vocational Nurse examination and licensure you must submit the following:

- A. **Application for Vocational Nurse Licensure (55A-1)** – Complete and sign the Application for Vocational Nurse Licensure.
- B. **Social Security Number*** – Business and Professions Code Section 30 and Public Law 94-455 [(42 USCA(c) (2) (C))] authorize collection of your Social Security Number. Applications for licensure will not be processed until a valid U.S. Social Security Number is received.
- C. **Photograph** – In a sealed envelope, **include** one 2" X 2" front view, head and shoulders, photograph of yourself. Please **sign** your name on the back of the photograph. This picture **must** be current.
- D. **Fingerprints** – See enclosed "**IMPORTANT FINGERPRINT INFORMATION**". The Board requires a Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) criminal history background check on all applicants. *Note: A LICENSE WILL NOT BE ISSUED UNTIL THE BOARD RECEIVES THE BACKGROUND INFORMATION FROM DOJ.*
- E. **Fee** – Attach a check for \$150.00 made payable to the "BVNPT". This is a non-refundable fee that covers the application process. Do **NOT** send cash. **If you will be submitting the hard card fingerprints rather than live scan fingerprints, you must also submit the \$51.00 fingerprint processing fees. (See "Important Fingerprint Information" enclosed.)**
- F. **Proof of 12th Grade Education** – **Attach** proof of 12th grade education or its equivalent. A copy of your high school diploma **or** GED Certificate is acceptable.
- G. **Record of Conviction (55A-6)** – **Complete and sign** the Record of Conviction. Failure to complete this form accurately may delay the processing of your application.
- H. **Postcard (55A-7)** – Write your name and address on the postcard provided. Make sure to place a postage stamp on the postcard to receive verification that your application was received by the Board. (Note: Not applicable for applications downloaded from the internet.)
- I. **Other Required Documents** – See Step #2 and your specific method of qualifying to ascertain any other documents which must be submitted for examination and licensure.

STEP #2

SUMMARY OF REQUIREMENTS FOR LICENSURE – Read the enclosed “Summary of Requirements for Licensure (Form # 55A-9)” to determine which method may qualify you for the Vocational Nurse examination and licensure. Follow the instructions below for the method by which you qualify:

Method #1 – Graduates of California Accredited Schools of Vocational Nursing in California.

Instructions are on file with each school. Applications **must** be submitted by the Director of your Nursing Program. Contact your program director for application instructions.

Method #2 – Graduates of an Out-of-State School of Practical/Vocational Nursing.

- **Submit all items listed in Step #1 on the first page of these instructions.**
- **Record of Nursing Program and Official Transcripts (Form 55A-2)** - Send this form to your school of practical/vocational nursing for completion and request that the school return the completed form to you with an official certified transcript in a sealed business envelope. **You must submit the sealed business envelope containing the Record of Nursing Program and official transcripts with your application for licensure.**

Method #3 – Equivalent Education and/or Experience.

- **Submit all items listed in Step #1 on the first page of these instructions.**
- **In addition, you must submit the following documentation with your application for licensure:**
 - **Record of Nursing Program and Official Transcripts (Form 55A-2)** – If you attended nursing school, send this form to your school for completion and request that the school return the completed form to you with an official certified transcript in a sealed business envelope. Transcripts received from the school in a foreign language will also require a certified English-language translation completed either by the school or by an independent professional translator who is not related to the applicant. **You must submit the sealed business envelope containing the Record of Nursing Program and official transcripts with your application for licensure.**
 - **Record of Nursing Experience (Form 55A-3)** - Complete this form and submit it with your application for licensure.
 - **Employment Verification – Nursing Experience (Form 55A-12)** – Complete Part I of this form. Provide copies to all of the employers that you listed on the Record of Nursing Experience (you may reproduce as many copies as needed). The RN Director or Supervisor must complete the remainder of the form and return it to you in a sealed business envelope. **You must submit the UNOPENED sealed business envelope(s) containing the completed Employment Verification Forms with your application for licensure.**
 - **Proof of 54 Theory Hours of Pharmacology** –Verification of 54 theory hours of pharmacology may be submitted on the Record of Nursing Program **or** a copy of the Course Completion Certificate specifying completion of 54 theory hours of pharmacology **and the grade earned**. You must submit the sealed business envelope containing the Record of Nursing Program or Course Completion Certificate with your application for licensure. **(See Summary of Requirements for Licensure as a Vocational Nurse (Form 55A-9) for required course content.)**

Method #4 – Military Applicants.

- **Submit all items listed in Step #1 on the first page of these instructions.**
- **Record of Military Service (Form 55A-4)** - Complete this form in full.
- **In addition, you must submit:**
 1. Copies of military service evaluations showing the dates of service, wards assigned and duties performed for each assignment. You must demonstrate that you rendered at least twelve (12) months of **active duty bedside patient care**.
 2. Transcripts or “Certificate of Release or Discharge from Active Duty” (DD214) showing completion of basic course of instruction in nursing required by his or her particular branch of the Armed Forces.
 3. DD214 or other military document showing that service in the Armed Forces has been under honorable conditions, or whose general discharge has been under honorable conditions.

Currently Licensed as a Practical/Vocational Nurse in Another State

If you are currently licensed as a Practical/Vocational Nurse in another U.S. State or territory, **you have received the wrong application package**. Please contact the Board at (916) 263-7800 and request an Application for Licensure by Endorsement.

IMPORTANT INFORMATION

Address Change

- If you change your address after submitting your application for licensure, you **must** notify the Board in writing, **immediately, but no later than thirty (30) days from the date of the address change**.

Application Materials

- The documents you submit **will not** be returned to you.
- The Record of Nursing Program **must** be completed by the Director of your educational program and accompanied by an official certified transcript. These documents must be submitted to the Board with your application in an unopened, sealed business envelope from the school.
- Only official transcripts are acceptable (photocopies are not accepted.) Official transcripts **must** list subjects and hours (theory and clinical) completed and the grades received for each subject area. Foreign transcripts **must** be accompanied by a certified translation if not in English.
- Employment verification forms must be submitted with your application in an unopened, sealed business envelope. Employment verification forms that appear to have been opened and/or altered will not be accepted.

Fees

- The fees for evaluation of your application and processing your fingerprint cards are non-refundable. In addition, please be advised that the fingerprint processing fees are subject to change without notice by the DOJ and FBI. **All applicants for licensure by examination are required to attach a check or money order made payable to the “BVNPT” with their application. Please do not send cash.**

APPLICATION FOR LICENSURE BY EXAMINATION FEE

Application Fee \$150.00

FINGERPRINT PROCESSING FEES

FBI Fingerprint Card Processing Fee \$19.00

DOJ Fingerprint Card Processing Fee \$32.00

\$51.00**

RETAKE APPLICATION FOR LICENSURE BY EXAMINATION FEE

Application Fee **\$150.00*****

NCLEX® REGISTRATION

After the Board has determined your eligibility for examination you will be mailed a National Council Licensure Examination (NCLEX®) Candidate Bulletin which contains the examination registration information. You must submit a completed NCLEX® Registration form and NCLEX® Registration Fee to the Data Center each time you apply to take the examination. See “NCLEX Registration Process” below for details.

NCLEX® Registration Fee \$200.00

INITIAL LICENSE FEE

When all requirements for licensure have been met, the Board will advise you of the Initial License Fee to be paid. This fee is in addition to the application evaluation fee.

Filing Deadlines/Processing Times

- Applications are accepted on a year-round basis. There are no specific filing deadlines. However, appointments for testing are made on a first-come, first-serve basis.
- You are encouraged to file your application for examination at least three (3) months prior to your anticipated testing date to allow sufficient time for evaluation. **It takes approximately eight (8) weeks for initial processing. You will be notified at that time if additional information is needed to complete the evaluation of your application.**

Name Change

- If you change your name please notify the Board in writing and attach a copy of one (1) of the following documents: Marriage Certificate, Divorce Decree, Passport, or Driver's License.

NCLEX® Registration Process

- After the Board has determined your eligibility for examination you will be mailed a National Council Licensure Examination (NCLEX®) Candidate Bulletin which contains the examination registration information. Eligible candidates must register with the NCLEX Data Center within 180 days (6 months) of this notification.
- The NCLEX® Registration procedures are:

Registration by Mail

- a. **Complete** the Registration Application Form
- b. **Attach** a money order **or** cashier's check for \$200.00 made payable to "NCSBN"
- c. **Mail** the Registration Application Form **and** fee to the NCLEX® Data Center

Registration by Telephone

- a. **Complete** the Registration Application Form
- b. **Call** the NCLEX® Data Center Directly, using the toll free number on the application form
- c. Provide the operator with all of the information contained on the Registration Application Form
- d. Provide the operator with your VISA or MasterCard credit card number **and** expiration date. The registration fee is \$200.00

Registration by Internet

- a. For internet registration go to www.vue.com/nclex, and follow the instructions provided. The registration fee is \$200.00.

Scheduling Your Appointment to Test

- When NCLEX® Data Center has processed your registration and verified your eligibility with the Board the **NCLEX® Data Center** will mail you an "Authorization to Test", along with a list of Testing Centers.
- Select the Testing Center most convenient for you. Call that Testing Center **and** schedule your appointment to take the test.
- The Testing Center is required to ensure that all eligible first-time applicants are scheduled within thirty (30) days of their requested test date. In addition, all eligible repeat applicants will be scheduled within forty-five (45) days of their requested test date.

Special Accommodations for Disabled Candidates

- Special testing accommodations are available for candidates with disabilities. Disabled candidates must notify the Board prior to scheduling an appointment to test, to obtain the requirements for requesting special accommodations.

* **Disclosure of your Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c) (2) (C))] authorize collection of your Social Security Number. Your Social Security Number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your Social Security Number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board.**

** **The DOJ currently requires live scan fingerprint services for California residents. Applicants submitting live scan fingerprints will be required to pay the fingerprint processing fees at the live scan station. All applicants residing out-of-state must submit hard card fingerprints. If you reside outside of California and will be submitting the "hard card" fingerprints rather than live scan fingerprints, you must include the \$51.00 fingerprint processing fees with your fingerprint cards. The fingerprint processing fees may be combined with the application fee and submitted to the Board on one check or money order, made payable to the "BVNPT" (see "Important Fingerprint Information" enclosed).**

*** **Retake applicants are not required to submit fingerprint cards and the applicable processing fees unless they have not previously satisfied this requirement, or the original application was abandoned. Applicants are only required to submit fingerprints and associated processing fees one time.**



SUMMARY OF REQUIREMENTS FOR LICENSURE **AS A VOCATIONAL NURSE**

ALL APPLICANTS FOR LICENSURE AS A VOCATIONAL NURSE IN CALIFORNIA MUST MEET **ALL** OF THE REQUIREMENTS UNDER SECTION A, AND **ONE** OF THE FOUR METHODS OF QUALIFYING FOR EXAMINATION IN SECTION B.

SECTION A

1. BE AT LEAST 17 YEARS OF AGE.
2. FURNISH PROOF OF COMPLETION OF THE 12TH GRADE OF SCHOOLING OR ITS EQUIVALENT.
3. COMPLETE AND SIGN THE "APPLICATION FOR VOCATIONAL NURSE LICENSURE" AND FURNISH A VALID U.S. SOCIAL SECURITY NUMBER.
4. COMPLETE AND SIGN THE "RECORD OF CONVICTION" FORM.
5. NOT BE SUBJECT TO DENIAL PURSUANT TO BUSINESS & PROFESSIONS CODE SECTION 480
6. SUBMIT THE REQUIRED DEPARTMENT OF JUSTICE (DOJ) AND FEDERAL BUREAU OF INVESTIGATION (FBI) FINGERPRINTS. (SEE ENCLOSED "IMPORTANT FINGERPRINT INFORMATION.") **NOTE: A LICENSE WILL NOT BE ISSUED UNTIL THE BOARD RECEIVES THE BACKGROUND INFORMATION FROM DOJ.**
7. ATTACH THE APPROPRIATE NONREFUNDABLE FEE MADE PAYABLE TO THE "BVNPT" (SEE PAGE 3 OF ENCLOSED "INSTRUCTIONS TO APPLICANTS FOR LICENSURE AS A LICENSED VOCATIONAL NURSE".)
8. SUCCESSFULLY COMPLETE A WRITTEN EXAMINATION TITLED "NATIONAL COUNCIL LICENSING EXAMINATION FOR PRACTICAL (VOCATIONAL) NURSING (NCLEX PN)" OR THE "NATIONAL LEAGUE FOR NURSING TEST POOL PRACTICAL NURSING EXAMINATION (NLN)". A PASSING SCORE ON A REGISTERED NURSE EXAMINATION WILL NOT SATISFY THIS REQUIREMENT.
9. SUBMIT THE INITIAL LICENSE FEE. WHEN YOU QUALIFY FOR LICENSURE THE BOARD WILL ADVISE YOU OF THE INITIAL LICENSE FEE TO BE PAID. THIS FEE IS IN ADDITION TO THE APPLICATION FEE. IT TAKES 4-6 WEEKS TO PROCESS YOUR LICENSE ONCE THIS FEE HAS BEEN RECEIVED.

SECTION B - TO BE DEEMED ELIGIBLE FOR EXAMINATION, YOU MUST QUALIFY BY ONE OF THE FOLLOWING METHODS:

1. **GRADUATE OF A CALIFORNIA ACCREDITED SCHOOL OF VOCATIONAL NURSING.**

YOU MUST HAVE SUCCESSFULLY COMPLETED A CALIFORNIA ACCREDITED VOCATIONAL NURSING PROGRAM.

2. **GRADUATE OF AN OUT-OF-STATE SCHOOL OF PRACTICAL/VOCATIONAL NURSING.**

THE SCHOOL OF PRACTICAL/VOCATIONAL NURSING FROM WHICH YOU GRADUATED MUST HAVE BEEN ACCREDITED BY THE BOARD OF NURSING IN THE STATE IN WHICH IT IS LOCATED AND THE COURSE CONTENT MUST HAVE BEEN SUBSTANTIALLY EQUIVALENT TO CALIFORNIA CURRICULUM REQUIREMENTS.

*LICENSURE IN ANOTHER STATE DOES **NOT** ENTITLE YOU TO PRACTICE AS A LICENSED VOCATIONAL NURSE IN CALIFORNIA. IN ORDER TO PRACTICE AS A LICENSED VOCATIONAL NURSE IN CALIFORNIA, YOU MUST BE LICENSED BY THE CALIFORNIA STATE BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS.*

3. EQUIVALENT EDUCATION AND/OR EXPERIENCE.

THIS METHOD **REQUIRES** YOU TO COMPLETE WITHIN TEN (10) YEARS PRIOR TO THE DATE OF APPLICATION, NOT LESS THAN FIFTY-ONE (51) MONTHS OF PAID **GENERAL DUTY INPATIENT BEDSIDE NURSING EXPERIENCE IN A CLINICAL FACILITY**, AT LEAST HALF OF WHICH SHALL HAVE BEEN WITHIN FIVE (5) YEARS PRIOR TO THE DATE OF APPLICATION. *PAID GENERAL DUTY INPATIENT BEDSIDE NURSING EXPERIENCE IS THE PERFORMANCE OF DIRECT PATIENT CARE FUNCTIONS PROVIDED THROUGHOUT THE PATIENT'S STAY THAT ENCOMPASS THE BREADTH AND DEPTH OF EXPERIENCE EQUIVALENT TO THAT PERFORMED BY THE LICENSED VOCATIONAL NURSE.* YOU MUST ALSO COMPLETE A PHARMACOLOGY COURSE OF AT LEAST 54 THEORY HOURS.

A. THE PHARMACOLOGY COURSE (54 THEORY HOURS) SHALL INCLUDE, BUT IS NOT LIMITED TO:

- KNOWLEDGE OF COMMONLY USED DRUGS AND THEIR ACTION
- COMPUTATION OF DOSAGES
- PREPARATION OF MEDICATIONS
- PRINCIPLES OF ADMINISTRATION

B. THE 51 MONTHS OF EXPERIENCE SHALL INCLUDE A MINIMUM OF EACH OF THE FOLLOWING:

- 48 MONTHS MEDICAL/SURGICAL NURSING
- 6 WEEKS MATERNITY OR GENITOURINARY NURSING
- 6 WEEKS PEDIATRIC NURSING

C. EXPERIENCE IN ANY OF THE FOLLOWING AREAS MAY BE SUBSTITUTED FOR A MAXIMUM OF EIGHT (8) MONTHS OF MEDICAL/SURGICAL EXPERIENCE:

- COMMUNICABLE DISEASE NURSING
- PUBLIC HEALTH NURSING
- OCCUPATIONAL HEALTH NURSING
- OFFICE NURSING (M.D.)
- PSYCHIATRIC NURSING
- OPERATING ROOM NURSING
- GERONTOLOGICAL NURSING
- PRIVATE DUTY NURSING (IN AN ACUTE CARE FACILITY ONLY)
- EMERGENCY ROOM NURSING
- OUT PATIENT CLINIC
- POST ANESTHESIA RECOVERY NURSING
- HEMODIALYSIS NURSING
- REHABILITATION NURSING
- EMERGENCY MEDICAL TECHNICIAN SERVICE

D. EXPERIENCE MUST BE VERIFIED BY THE EMPLOYER SHOWING SPECIFIC DATES OF EMPLOYMENT AND SHALL INCLUDE CERTIFICATION FROM THE R.N. DIRECTOR OR SUPERVISOR THAT THE APPLICANT HAS SATISFACTORILY DEMONSTRATED THE FOLLOWING KNOWLEDGE AND SKILLS:

1. BASIC BEDSIDE NURSING

- AMBULATION TECHNIQUES
- BEDMAKING
- URINARY CATHETER CARE
- COLLECTION OF SPECIMENS
- DIABETIC TESTING
- ADMINISTRATION OF A CLEANSING ENEMA
- FEEDING PATIENT
- COMMUNICATION SKILLS, BOTH VERBAL AND WRITTEN, INCLUDING COMMUNICATION WITH PATIENTS WHO HAVE PSYCHOLOGICAL DISORDERS
- INTAKE AND OUTPUT
- PERSONAL HYGIENE AND COMFORT MEASURES
- POSITIONING AND TRANSFER
- RANGE OF MOTION
- SKIN CARE
- VITAL SIGNS
- HOT AND COLD APPLICATIONS

2. INFECTON CONTROL PROCEDURES (MAY BE DEMONSTRATED IN CLASSROOM, LAB, AND/OR PATIENT CARE SETTINGS)

- ASEPSIS
- TECHNIQUES FOR STRICT, CONTACT, RESPIRATORY, ENTERIC, TUBERCULOSIS, DRAINAGE, UNIVERSAL AND IMMUNOSUPPRESSED PATIENT ISOLATION.

APPLICANTS WITH FORMAL NURSING EDUCATION MAY SUBMIT OFFICIAL TRANSCRIPTS FOR EVALUATION FOR POSSIBLE CREDIT IN LIEU OF PAID BEDSIDE NURSING EXPERIENCE. THE TRANSCRIPTS MUST BE SUBMITTED TO THE BOARD DIRECTLY FROM THE SCHOOL AND MUST SHOW THEORY AND CLINICAL HOURS COMPLETED.

4. NURSING SERVICE IN THE MEDICAL CORPS OF ANY BRANCH OF THE ARMED FORCES OF THE UNITED STATES. THIS METHOD REQUIRES:

- A. MILITARY SERVICE EVALUATIONS SHOWING AT LEAST TWELVE (12) MONTHS SERVICE ON ACTIVE DUTY IN THE MEDICAL CORPS OF ANY OF THE ARMED FORCES RENDERING BEDSIDE PATIENT CARE. MILITARY SERVICE EVALUATIONS MUST BE SUBMITTED SHOWING THE DATES OF SERVICE, WARDS ASSIGNED, AND THE DUTIES PERFORMED FOR EACH ASSIGNMENT.
- B. TRANSCRIPTS OR "CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY" (DD 214) SHOWING COMPLETION OF BASIC COURSE OF INSTRUCTION IN NURSING REQUIRED BY HIS OR HER PARTICULAR BRANCH OF THE ARMED FORCES.
- C. DD 214 OR OTHER MILITARY DOCUMENT SHOWING THAT SERVICE IN THE ARMED FORCES HAS BEEN UNDER HONORABLE CONDITIONS, OR WHOSE GENERAL DISCHARGE HAS BEEN UNDER HONORABLE CONDITIONS.

NOTE: A COMBINATION OF MILITARY AND NONMILITARY EXPERIENCE IS NOT ACCEPTABLE UNDER THIS METHOD. PROOF OF 12TH GRADE EDUCATION IS NOT REQUIRED UNDER THIS METHOD.

NOTE: STATE BOARDS OF NURSING IN MANY STATES REQUIRE GRADUATION FROM AN ACCREDITED SCHOOL OF NURSING. PLEASE BE AWARE THAT APPLICANTS DEEMED ELIGIBLE FOR LICENSURE IN CALIFORNIA USING OTHER METHODS OF QUALIFYING (I.E., MILITARY EXPERIENCE OR EQUIVALENT EDUCATION AND EXPERIENCE) MAY NOT BE ELIGIBLE FOR LICENSURE BY ENDORSEMENT IN OTHER STATES.



APPLICATION FOR VOCATIONAL NURSE LICENSURE

(ATTACH \$150 APPLICATION FEE. AN ADDITIONAL \$51 FINGERPRINT FEE IS REQUIRED FOR PROCESSING "HARD CARD" FINGERPRINTS – SEE ENCLOSED INSTRUCTIONS.)

Read all the enclosed instructions carefully before completing this application. This information is required under Business and Professions Code Division 2, Chapter 6.5, Articles 1 and 2. The information you furnish will be used to determine your eligibility for licensure. If additional space is needed to complete any section of this application, please attach additional sheets. The Executive Officer of the Board is responsible for information maintenance.

| | |
|----------------------------|--|
| DO NOT WRITE IN THIS SPACE | |
| APP. NO | |
| LIC. NO | |
| ILF-CA NO. | |
| ATS NO. | |

PRINT OR TYPE (DO NOT USE PENCIL)

| | | |
|---|----------------------------|--|
| 1. NAME (LAST) (FIRST) (MIDDLE) | | |
| 2. ADDRESS (STREET OR BOX NUMBER) (APT. NO) | | |
| 3. CITY STATE ZIP | | |
| 4. BIRTHDATE (Month/Day/Year) | 5. SOCIAL SECURITY NUMBER* | 6. TELEPHONE NUMBER Business () Home () Area Code |
| 7. DID YOU GRADUATE FROM HIGH SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF HIGH SCHOOL: CITY/STATE: | | |
| DID YOU PASS A HIGH SCHOOL EQUIVALENCY TEST? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, CIRCLE THE HIGHEST GRADE YOU COMPLETED 1 2 3 4 5 6 7 8 9 10 11 12 | | |
| 8. DID YOU ATTEND A <u>VOCATIONAL/PRACTICAL NURSING</u> PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO DID YOU GRADUATE FROM THE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME OF VOCATIONAL/PRACTICAL NURSING PROGRAM: DATE STARTED: DATE COMPLETED: STATE OR COUNTRY: | | |
| 9. DID YOU ATTEND A <u>REGISTERED NURSING</u> PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO DID YOU GRADUATE FROM THE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME OF REGISTERED NURSING PROGRAM: DATE STARTED: DATE COMPLETED: STATE OR COUNTRY: | | |
| 10. HAVE YOU EVER BEEN LICENSED AS A VOCATIONAL/PRACTICAL NURSE? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE LICENSED: STATE OF ORIGINAL LICENSE: IF YES, HAS THIS LICENSE EVER BEEN SUSPENDED, REVOKED OR PLACED ON PROBATION? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, ATTACH EXPLANATION) | | |
| 11. HAVE YOU EVER BEEN LICENSED AS A REGISTERED NURSE? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE LICENSED: STATE OF ORIGINAL LICENSE: IF YES, HAS THIS LICENSE EVER BEEN SUSPENDED, REVOKED OR PLACED ON PROBATION? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, ATTACH EXPLANATION) | | |
| 12. HAVE YOU EVER APPLIED TO THIS BOARD FOR LICENSURE UNDER A DIFFERENT NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", PLEASE LIST OTHER NAMES: WILL DOCUMENTS BE SUBMITTED TO THIS BOARD UNDER A DIFFERENT NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST OTHER NAMES: | | |
| 13. CONFIDENTIALITY NOTICE: YOU ARE ADVISED THAT PURSUANT TO BUSINESS AND PROFESSIONS CODE, SECTION 123, THE CONTENT OF THE VOCATIONAL NURSE LICENSURE EXAMINATION IS CONFIDENTIAL. IF YOU ARE DEEMED ELIGIBLE TO TAKE THIS EXAMINATION, YOU ARE HEREBY NOTIFIED THAT UNAUTHORIZED POSSESSION, REPRODUCTION, OR DISCLOSURE OF ANY EXAMINATION MATERIALS IS IN VIOLATION OF THE LAW AND SUBJECT TO CRIMINAL MISDEMEANOR PROSECUTION. A VIOLATION OF THIS TYPE MAY ALSO RESULT IN CIVIL LIABILITY AND/OR DISCIPLINE BY THE LICENSING AGENCY INCLUDING THE DENIAL OF LICENSURE. | | |
| 14. PHOTOGRAPH REQUIREMENTS: YOU <u>MUST</u> ATTACH A CURRENT, FRONT VIEW, HEAD AND SHOULDER PHOTOGRAPH OF YOURSELF IN A SEALED ENVELOPE. THE PHOTOGRAPH SHOULD BE 2" X 2" AND <u>MUST</u> BE SIGNED ON THE BACK. | | |
| 15. PLEASE READ CAREFULLY BEFORE SIGNING. – I hereby certify, under penalty of perjury under the laws of the State of California, that the foregoing, including any attachments, is true and correct. False statements included in this application can result in licensure denial. | | |
| SIGNATURE: _____ | | DATE: _____ |
| SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT – Disclosure of your Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c) (2) (C))] authorizes collection of your Social Security Number. Your Social Security Number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your Social Security Number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you. | | |



RECORD OF NURSING PROGRAM

The applicant should complete the first section of this form and provide it to the Director of the nursing program. The Director of the nursing program should complete the information in the second section and return it to the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT (ITEMS 1-6). PRINT OR TYPE (DO NOT USE PENCIL).

| | | |
|---|----------------------------------|---|
| 1. NAME (LAST) _____ (FIRST) _____ (MIDDLE) _____ | | |
| 2. ADDRESS _____ (STREET OR BOX NUMBER) _____ (APT. NO) _____ | | |
| 3. CITY _____ STATE _____ ZIP _____ | | |
| 4. BIRTHDATE (Month/Day/Year) _____ | 5. SOCIAL SECURITY NUMBER* _____ | 6. TELEPHONE NUMBERS BUSINESS () _____ HOME () _____ AREA CODE _____ |

THIS SECTION TO BE COMPLETED BY SCHOOLS OF VOCATIONAL, PRACTICAL OR REGISTERED NURSING. PRINT OR TYPE (DO NOT USE PENCIL)

| | | |
|--|--------------------------------------|--|
| 7. NAME OF SCHOOL OF VOCATIONAL OR PRACTICAL NURSING: _____ CITY _____ STATE _____ | | |
| DATE PROGRAM STARTED: _____ DATE PROGRAM COMPLETED: _____ OR DATE VERIFIED HOURS WERE COMPLETED _____ | | |
| WAS PROGRAM "ACCREDITED" WHEN HOURS WERE COMPLETED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 8. NAME OF SCHOOL OF REGISTERED NURSING: _____ CITY _____ STATE _____ | | |
| DATE PROGRAM STARTED: _____ DATE PROGRAM COMPLETED: _____ OR DATE VERIFIED HOURS WERE COMPLETED _____ | | |
| WAS PROGRAM "ACCREDITED" WHEN HOURS WERE COMPLETED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 9. COMPLETION OF THE TWELFTH (12 TH) GRADE IN HIGH SCHOOL OR ITS EQUIVALENT HAS BEEN PROVEN BY THE APPLICANT AS FOLLOWS: | | |
| <input type="checkbox"/> PRESENTED OFFICIAL SCHOOL RECORDS SHOWING COMPLETION OF 12 TH GRADE HIGH SCHOOL | | |
| <input type="checkbox"/> PASSED THE "GED" TEST AT THE 12 TH GRADE LEVEL | | |
| 10. A. TOTAL NUMBER OF THEORY/CLINICAL HOURS COMPLETED IN <u>YOUR</u> NURSING PROGRAM: | | |
| THEORY: _____ HOURS CLINICAL: _____ HOURS | | |
| B. TOTAL NUMBER OF THEORY/CLINICAL HOURS WHICH YOUR SCHOOL GRANTED CREDIT FOR "PREVIOUS EDUCATION": | | |
| THEORY: _____ HOURS CLINICAL: _____ HOURS | | |
| C. COMPLETE THE SECOND PAGE OF THIS FORM IN FULL. THIS IS A MANDATORY REQUIREMENT. | | |
| 11. I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT. | | |
| (SCHOOL SEAL) | SIGNATURE OF PROGRAM DIRECTOR: _____ | |
| | PRINT PROGRAM DIRECTOR'S NAME: _____ | |
| | DATE: _____ | |
| * SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT – Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c)(2)(C))] authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board. | | |

RECORD OF NURSING PROGRAM

THIS SECTION OF THE FORM MUST BE COMPLETED IN FULL.

| | | |
|--|---|-----------------------------------|
| 1. NAME OF SCHOOL OF NURSING: _____ CHECK ONE: <input type="checkbox"/> VOCATIONAL/PRACTICAL NURSING PROGRAM <input type="checkbox"/> REGISTERED NURSING PROGRAM | 2. CITY _____ | 3. STATE AND COUNTRY _____ |
| 4. DATE PROGRAM STARTED: _____ <div style="text-align: center;">(MONTH/DAY/YEAR)</div> | 5. DATE VERIFIED HOURS WERE COMPLETED: _____ <div style="text-align: center;">(MONTH/DAY/YEAR)</div> | |

| 6. SUBJECT | ACTUAL HOURS/UNITS COMPLETED | | CHECK HERE IF SUBJECT IS INTEGRATED | GRADE RECEIVED | | HOURS/UNITS OF CREDIT GRANTED FOR PREVIOUS LEARNING | |
|-----------------------------|------------------------------|----------|---|----------------|----------|---|----------|
| | THEORY | CLINICAL | | THEORY | CLINICAL | THEORY | CLINICAL |
| ANATOMY & PHYSIOLOGY | | N/A | | | N/A | | N/A |
| NUTRITION | | N/A | | | N/A | | N/A |
| PHARMACOLOGY | | N/A | | | N/A | | N/A |
| PSYCHOLOGY | | N/A | | | N/A | | N/A |
| NORMAL GROWTH & DEVELOPMENT | | N/A | | | N/A | | N/A |
| NURSING FUNDAMENTALS | | | | | | | |
| NURSING PROCESS | | | | | | | |
| MEDICAL SURGICAL NURSING | | | | | | | |
| COMMUNICABLE DISEASES | | | | | | | |
| MATERNITY NURSING | | | | | | | |
| PEDIATRIC NURSING | | | | | | | |
| GERONTOLOGICAL NURSING | | | | | | | |
| REHABILITATION NURSING | | | | | | | |
| LEADERSHIP | | N/A | | | N/A | | N/A |
| SUPERVISION | | N/A | | | N/A | | N/A |
| COMMUNICATION | | N/A | | | N/A | | N/A |
| PATIENT EDUCATION | | N/A | | | N/A | | N/A |
| ETHICS & UNETHICAL CONDUCT | | N/A | | | N/A | | N/A |
| CRITICAL THINKING | | N/A | | | N/A | | N/A |
| CULTURALLY CONGRUENT CARE | | | | | | | |
| END OF LIFE CARE | | | | | | | |
| TOTAL HOURS: | | | | | | | |



RECORD OF NURSING EXPERIENCE

PRINT OR TYPE (DO NOT USE PENCIL).

| | | |
|---|----------------------------|---|
| 1. NAME (LAST) | (FIRST) | (MIDDLE) |
| 2. ADDRESS (STREET OR BOX NUMBER) (APT. NO) | | |
| 3. CITY STATE ZIP | | |
| 4. BIRTHDATE (month/day/year) | 5. SOCIAL SECURITY NUMBER* | 6. TELEPHONE NUMBERS BUSINESS () _____ HOME () _____ AREA CODE _____ |

EXPERIENCE: List all nursing experience for the past ten (10) years for which you will be submitting verification of employment. It is your responsibility to contact each employer and provide them with a copy of the Employment Verification – Nursing Experience Form for completion.

| | | | |
|--|--|---|---|
| 7A. Name of Hospital, Registry or Health Agency: Name of RN Director or Supervisor: Your name while employed at this facility: | Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private Type of Patient Care for: <input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Maternity <input type="checkbox"/> Pediatric <input type="checkbox"/> Other: _____ | Employment Period From: _____ Month Day Year To: _____ Month Day Year | <i>THIS SPACE FOR OFFICE USE ONLY</i> |
| 7B. Name of Hospital, Registry or Health Agency: Name of RN Director or Supervisor: Your name while employed at this facility: | Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private Type of Patient Care for: <input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Maternity <input type="checkbox"/> Pediatric <input type="checkbox"/> Other: _____ | Employment Period From: _____ Month Day Year To: _____ Month Day Year | |
| 7C. Name of Hospital, Registry or Health Agency: Name of RN Director or Supervisor: Your name while employed at this facility: | Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private Type of Patient Care for: <input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Maternity <input type="checkbox"/> Pediatric <input type="checkbox"/> Other: _____ | Employment Period From: _____ Month Day Year To: _____ Month Day Year | |

NOTE: IF MORE SPACE IS NEEDED, PLEASE COMPLETE THE SECOND PAGE OF THIS FORM.

PLEASE READ CAREFULLY BEFORE SIGNING. – I hereby certify under penalty of perjury under the laws of the State of California that the information herein, including any attachments, is true and correct. False statements included in this application can result in licensure denial.

SIGNATURE: _____ DATE: _____

*** SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT –**

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [42 USCA (c)(2)(C)] authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

| | | | |
|--|---|--|--|
| <p>7C. Name of Hospital, Registry or Health Agency:</p> <p>_____</p> <p>Name of RN Director or Supervisor:</p> <p>_____</p> <p>Your name while employed at this facility:</p> <p>_____</p> | <p>Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private</p> <p>Type of Patient Care for:</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Surgical</p> <p><input type="checkbox"/> Maternity</p> <p><input type="checkbox"/> Pediatric</p> <p><input type="checkbox"/> Other: _____</p> | <p>Employment Period</p> <p>From: _____</p> <p>Month Day Year</p> <p>To: _____</p> <p>Month Day Year</p> | <p><i>THIS SPACE FOR OFFICE USE ONLY</i></p> |
| <p>7E. Name of Hospital, Registry or Health Agency:</p> <p>_____</p> <p>Name of RN Director or Supervisor:</p> <p>_____</p> <p>Your name while employed at this facility:</p> <p>_____</p> | <p>Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private</p> <p>Type of Patient Care for:</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Surgical</p> <p><input type="checkbox"/> Maternity</p> <p><input type="checkbox"/> Pediatric</p> <p><input type="checkbox"/> Other: _____</p> | <p>Employment Period</p> <p>From: _____</p> <p>Month Day Year</p> <p>To: _____</p> <p>Month Day Year</p> | |
| <p>7F. Name of Hospital, Registry or Health Agency:</p> <p>_____</p> <p>Name of RN Director or Supervisor:</p> <p>_____</p> <p>Your name while employed at this facility:</p> <p>_____</p> | <p>Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private</p> <p>Type of Patient Care for:</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Surgical</p> <p><input type="checkbox"/> Maternity</p> <p><input type="checkbox"/> Pediatric</p> <p><input type="checkbox"/> Other: _____</p> | <p>Employment Period</p> <p>From: _____</p> <p>Month Day Year</p> <p>To: _____</p> <p>Month Day Year</p> | |
| <p>7G. Name of Hospital, Registry or Health Agency:</p> <p>_____</p> <p>Name of RN Director or Supervisor:</p> <p>_____</p> <p>Your name while employed at this facility:</p> <p>_____</p> | <p>Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private</p> <p>Type of Patient Care for:</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Surgical</p> <p><input type="checkbox"/> Maternity</p> <p><input type="checkbox"/> Pediatric</p> <p><input type="checkbox"/> Other: _____</p> | <p>Employment Period</p> <p>From: _____</p> <p>Month Day Year</p> <p>To: _____</p> <p>Month Day Year</p> | |
| <p>7H. Name of Hospital, Registry or Health Agency:</p> <p>_____</p> <p>Name of RN Director or Supervisor:</p> <p>_____</p> <p>Your name while employed at this facility:</p> <p>_____</p> | <p>Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private</p> <p>Type of Patient Care for:</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Surgical</p> <p><input type="checkbox"/> Maternity</p> <p><input type="checkbox"/> Pediatric</p> <p><input type="checkbox"/> Other: _____</p> | <p>Employment Period</p> <p>From: _____</p> <p>Month Day Year</p> <p>To: _____</p> <p>Month Day Year</p> | |
| <p>7I. Name of Hospital, Registry or Health Agency:</p> <p>_____</p> <p>Name of RN Director or Supervisor:</p> <p>_____</p> <p>Your name while employed at this facility:</p> <p>_____</p> | <p>Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private</p> <p>Type of Patient Care for:</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Surgical</p> <p><input type="checkbox"/> Maternity</p> <p><input type="checkbox"/> Pediatric</p> <p><input type="checkbox"/> Other: _____</p> | <p>Employment Period</p> <p>From: _____</p> <p>Month Day Year</p> <p>To: _____</p> <p>Month Day Year</p> | |
| <p>7A. Name of Hospital, Registry or Health Agency:</p> <p>_____</p> <p>Name of RN Director or Supervisor:</p> <p>_____</p> <p>Your name while employed at this facility:</p> <p>_____</p> | <p>Type of Duty: <input type="checkbox"/> General <input type="checkbox"/> Private</p> <p>Type of Patient Care for:</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Surgical</p> <p><input type="checkbox"/> Maternity</p> <p><input type="checkbox"/> Pediatric</p> <p><input type="checkbox"/> Other: _____</p> | <p>Employment Period</p> <p>From: _____</p> <p>Month Day Year</p> <p>To: _____</p> <p>Month Day Year</p> | |



EMPLOYMENT VERIFICATION – NURSING EXPERIENCE

In order to receive credit for nursing experience, State law requires that the Board obtain verification of employment and certification from the Registered Nurse (RN) Director or Supervisor that the applicant has demonstrated the required knowledge and skills during the applicant's *paid general duty inpatient bedside nursing experience*.

INSTRUCTIONS TO APPLICANT:

- Complete Part I on the second page of this form and provide a copy of both pages to each employer for the past ten (10) years. (You may reproduce as many copies of this form as needed.)
- This form must be completed in full by the RN Director or Supervisor and **returned directly to you in the employer's sealed business envelope. The UNOPENED sealed envelopes containing the Employment Verification Forms must be submitted to the Board with your Application for Vocational Nurse Licensure.**
- If you already have an application on the file with the Board and are submitting additional experience, the employment verification form may be submitted to the Board by the applicant or the employer, but must be received in the employer's sealed business envelope.

Please be advised that employment verification forms that appear to have been opened or altered will not be accepted. The Board conducts random audits to verify the accuracy of the information submitted. Discrepancies or false statements included in the application can result in licensure denial.

INSTRUCTIONS TO EMPLOYER:

The applicant on page two of this form is applying for licensure as a vocational nurse under Section 2873 of the Business and Professions Code. In order for the applicant to receive credit for nursing experience, State law requires the Board to obtain verification of employment and certification from the RN Director or Supervisor that the applicant has demonstrated required knowledge and skills during the applicant's *paid general duty inpatient bedside nursing experience*.

- Please complete Parts II, III and IV on page two of this form and **return it to the applicant in a sealed business envelope.** Indicate on the outside of the envelope **"Employment Verification Enclosed – Do Not Open"**. It is the applicant's responsibility to collect the Employment Verification Form(s) and submit them with the application for licensure.
- **Part II:** Indicate the name and type of facility where the experience was obtained.
- **Part III:** Provide the specific dates that the applicant worked under your supervision, in the area of nursing being verified. Additionally, indicate if the applicant was employed full time (40 hrs./wk.) or part time and **include the number of hours worked in each area.** The Board MUST receive a breakdown of the number of hours spent in each area, in order to evaluate the experience.
- **Part IV:** Indicate whether the applicant has satisfactorily demonstrated each of the knowledge and skills with safety to the patient. The skills listed in Part IV(B) may be demonstrated in classroom, lab, and/or patient care settings.

Thank you for your assistance. Please feel free to contact the Board at (916) 263-7800 if you have any questions.

**BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
EMPLOYMENT VERIFICATION – NURSING EXPERIENCE**

Part I is to be completed by the applicant and submitted to employers for verification of nursing experience. The remainder of this form must be completed by the RN Director or Supervisor and returned to the applicant by the employer in a sealed business envelope. FORMS CONTAINING STRIKEOUTS OR CORRECTIONS WILL NOT BE ACCEPTED. (See Page 1 for detailed instructions on how to complete this form.)

Part I: To be completed by the Applicant (print or type - do not use pencil):

| | | |
|---|----------------------------|---|
| 1. NAME (LAST) | (FIRST) | (MIDDLE) |
| 2. ADDRESS (STREET OR BOX NUMBER) | | (APT. NO) |
| 3. CITY | STATE | ZIP |
| 4. NAME WHILE EMPLOYED AT THIS FACILITY: | 5. SOCIAL SECURITY NUMBER* | 6. DAYTIME TELEPHONE NUMBER () _____ Area Code |
| <small>*NOT required, but may assist employer in locating records</small> | | |

Part II: To be completed by the Employer - Indicate the name and type of facility where the experience was obtained:

| | | | |
|---|---|---|---|
| Name of facility where experience was obtained: | | | |
| Type of facility: | <input type="checkbox"/> Acute or sub-acute(hospital) | <input type="checkbox"/> Convalescent | <input type="checkbox"/> Skilled Nursing/Long Term Care |
| | <input type="checkbox"/> Home Health | <input type="checkbox"/> Outpatient Clinic/emergency care | <input type="checkbox"/> Assisted Living |
| | | <input type="checkbox"/> Other | |

Part III: To be completed by the Employer - Include dates and the area of nursing being verified. Indicate if employment was full-time (40 hrs/wk) or part-time and include the total number of hours worked in each area:

| Areas of Bedside Nursing Experience | Employment Period: (Month/Date/Year) | Hours Worked Per Week | Total Hours In Each Area | For Office Use Only |
|---|--------------------------------------|-----------------------|--------------------------|---------------------|
| Medical-Surgical Nursing | From: / / To: / / | | | |
| Pediatric Nursing | From: / / To: / / | | | |
| Maternity Nursing | From: / / To: / / | | | |
| Genitourinary Nursing | From: / / To: / / | | | |
| Psychiatric Nursing | From: / / To: / / | | | |
| Office Nursing | From: / / To: / / | | | |
| Long Term Care/Convalescent | From: / / To: / / | | | |
| Private Duty (in a general acute care facility) | From: / / To: / / | | | |
| Other: | From: / / To: / / | | | |

Part IV: To be completed by the Employer - Indicate if the applicant has satisfactorily demonstrated the following knowledge and skills with safety to the patient:

| Knowledge and Skills | Demonstrated | | Knowledge and Skills | Demonstrated | |
|--|--------------|----|--|--------------|----|
| | YES | NO | | YES | NO |
| A. Basic Bedside Nursing | | | | | |
| 1. Ambulation Techniques | | | 9. Intake and Output | | |
| 2. Bedmaking | | | 10. Personal Hygiene and Comfort Measures | | |
| 3. Urinary Catheter Care | | | 11. Positioning and Transfer | | |
| 4. Collection of Specimens | | | 12. Range of Motion | | |
| 5. Diabetic Testing | | | 13. Skin Care | | |
| 6. Administration of a Cleansing Enema | | | 14. Vital Signs | | |
| 7. Feeding Patient | | | 15. Communication Skills, Both Verbal and Written, Including Communication With Patients Who Have Psychological Disorders | | |
| 8. Hot and Cold Applications | | | | | |
| B. Infection Control Procedures (may be demonstrated in classroom, lab, and/or patient care settings) | | | | | |
| 1. Asepsis | | | 2. Techniques for strict, contact, respiratory, enteric, tuberculosis, drainage, universal and immunosuppressed patient isolation. | | |

TO BE SIGNED BY THE RN DIRECTOR OR SUPERVISOR: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.

Signature: _____
 Nursing License # _____ Exp. Date: _____
 Address: _____
 City/State: _____ Zip Code: _____

Print Name _____
 Telephone Number: (_____) _____
 Today's Date: _____



RECORD OF CONVICTION

PRINT OR TYPE (DO NOT USE PENCIL).

| | | |
|---|----------------------------------|---|
| 1. NAME (LAST) _____ (FIRST) _____ (MIDDLE) _____ | | |
| 2. ADDRESS (STREET OR BOX NUMBER) _____ (APT. NO) _____ | | |
| 3. CITY _____ STATE _____ ZIP _____ | | |
| 4. BIRTHDATE (Month/Day/Year) _____ | 5. SOCIAL SECURITY NUMBER* _____ | 6. TELEPHONE NUMBERS BUSINESS () _____ HOME () _____ AREA CODE _____ |

7. HAVE YOU EVER BEEN "CONVICTED" OF ANY OFFENSE, INCLUDING TRAFFIC VIOLATIONS? YES NO
 (NOTE: SEE BACK PAGE FOR MORE INFORMATION)

REMEMBER YOU **MUST INCLUDE:**

- **MISDEMEANORS AND FELONIES.** REGARDLESS OF LENGTH OF TIME WHICH HAS PASSED SINCE THE CONVICTION.
- ANY PLEA OF **NOLO CONTENDERE.** THIS IS CONSIDERED A CONVICTION FOR LICENSURE PURPOSES.
- ANY CONVICTION WHICH HAS BEEN **EXPUNGED** IN ACCORDANCE WITH PENAL CODE SECTION 1203.4.
- ANY OFFENSE FOR WHICH YOU WERE:
 - IMPRISONED
 - PLACED ON PROBATION OR FINED
 - ANY OFFENSE WHICH AROSE DURING YOUR MILITARY SERVICE
 - ANY OFFENSE IN WHICH THE IMPOSITION OR EXECUTION OF SENTENCE WAS SUSPENDED
 - ANY OFFENSE IN WHICH AN ORDER OF REHABILITATION WAS ENTERED
 - ANY RECORD OF CONVICTION WHICH WAS EXPUNGED OR A PARDON GRANTED

8. IF YOU ANSWERED **YES** TO ITEM 7, YOU **MUST PROVIDE ALL OF THE INFORMATION** REQUESTED BELOW FOR **EACH OFFENSE.** DEPARTMENT OF MOTOR VEHICLES PRINTOUTS ARE **NOT** ACCEPTED IN LIEU OF COMPLETING THIS SECTION.

A. DATE OF ARREST: _____ B. CITY AND STATE WHERE ARRESTED: _____

C. NAME AND LOCATION OF COURT WHERE CASE WAS HEARD (IF APPLICABLE): _____

D. DETAILS OF THE VIOLATION OF WHICH YOU WERE CONVICTED (attach additional pages if necessary): _____

E. DATES OF IMPRISONMENT: _____ F. AMOUNT OF FINE PAID: _____

G. PERIOD OF PROBATION: _____

H. CONDITIONS OF PROBATION: _____

I. NAME AND ADDRESS OF PROBATION OFFICER: _____

NOTE: IF YOU HAVE ADDITIONAL OFFENSES OR REQUIRE ADDITIONAL INFORMATION, PLEASE SEE THE SECOND PAGE OF THIS FORM.

9. ARE YOU OR HAVE YOU BEEN PREVIOUSLY LICENSED AS A PSYCHIATRIC TECHNICIAN, PRACTICAL, VOCATIONAL OR REGISTERED NURSE IN THIS OR ANY OTHER STATE, TERRITORY OR ANOTHER COUNTRY? YES NO

IF YOU ANSWERED "**YES**", YOU MUST PROVIDE THE FOLLOWING INFORMATION:

A. STATE OF LICENSURE: _____ LICENSE TYPE: PT LVN/LPN RN LICENSE # _____ EXPIRATION DATE: _____ NAME USED: _____

STATE OF LICENSURE: _____ LICENSE TYPE: PT LVN/LPN RN LICENSE # _____ EXPIRATION DATE: _____ NAME USED: _____

STATE OF LICENSURE: _____ LICENSE TYPE: PT LVN/LPN RN LICENSE # _____ EXPIRATION DATE: _____ NAME USED: _____

B. HAS YOUR LICENSE(S) EVER BEEN SUSPENDED OR REVOKED? YES NO

C. HAS YOUR LICENSE(S) EVER BEEN PLACED ON PROBATION? YES NO

IF YOU ANSWERED "**YES**" TO ITEM B & C ABOVE, YOU MUST EXPLAIN BASIS FOR DISCIPLINARY ACTION AND SUBMIT A COPY OF THE DISCIPLINARY ORDER FILED AGAINST YOUR LICENSE:

10. I hereby certify under penalty of perjury under the laws of the State of California that the information provided herein, including any attachments, is true and correct. False statements included in this application can result in licensure denial.

SIGNATURE: _____ DATE: _____

7. **ADDITIONAL INFORMATION** (CONTINUED FROM SECTION 7 ON FRONT PAGE):

YOU DO NOT HAVE TO REPORT:

- ANY TRAFFIC VIOLATIONS FOR WHICH THE ONLY SENTENCE IMPOSED WAS FINE OF *LESS THAN \$300*.
- ANY OFFENSE FOR WHICH *BAIL OF LESS THAN \$500* WAS FORFEITED.
- ANY INCIDENT OF WHICH THE RECORDS HAVE BEEN SEALED UNDER THE WELFARE & INSTITUTIONS CODE, SECTION 781 OR PENAL CODE SECTION 1203.45.
- ANY JUVENILE CONVICTION (UNDER THE AGE OF 18) **UNLESS YOU WERE TRIED AND CONVICTED AS AN ADULT.**

IF YOU HAVE BEEN CONVICTED OF A CRIME, PLEASE SUBMIT CERTIFIED COURT DOCUMENTS, POLICE REPORTS, AND A DETAILED EXPLANATION OF THE OFFENSE FOR EACH CONVICTION. YOU MAY ALSO WISH TO INCLUDE DOCUMENTS REGARDING YOUR EFFORTS AT REHABILITATION SUCH AS:

- PROOF YOU COMPLIED WITH TERMS OF PAROLE, PROBATION, RESTITUTION OR ANY OTHER COURT IMPOSED SANCTIONS
- EVIDENCE OF EXPUNGEMENT PROCEEDINGS PURSUANT TO PENAL CODE SECTION 1203.4
- ANY OTHER EVIDENCE OF REHABILITATION YOU WISH TO SUBMIT

IMPORTANT NOTE: YOU WILL BE PERMITTED TO TAKE THE LICENSING EXAMINATION. HOWEVER, A DETERMINATION AS TO WHETHER YOUR LICENSE WILL BE GRANTED OR DENIED WILL NOT BE MADE UNTIL YOU HAVE PASSED THE EXAMINATION.

8. IF YOU ANSWERED **YES** TO ITEM 7, YOU **MUST** PROVIDE **ALL OF THE INFORMATION** REQUESTED BELOW FOR **EACH OFFENSE**. DEPARTMENT OF MOTOR VEHICLES PRINTOUTS ARE **NOT** ACCEPTED IN LIEU OF COMPLETING THIS SECTION.

A. DATE OF ARREST: _____ B. CITY AND STATE WHERE ARRESTED: _____

C. NAME AND LOCATION OF COURT WHERE CASE WAS HEARD (IF APPLICABLE): _____

D. DETAILS OF THE VIOLATION OF WHICH YOU WERE CONVICTED (attach additional pages if necessary): _____

E. DATES OF IMPRISONMENT: _____ F. AMOUNT OF FINE PAID: _____

G. PERIOD OF PROBATION: _____

H. CONDITIONS OF PROBATION: _____

I. NAME AND ADDRESS OF PROBATION OFFICER: _____

8. IF YOU ANSWERED **YES** TO ITEM 7, YOU **MUST** PROVIDE **ALL OF THE INFORMATION** REQUESTED BELOW FOR **EACH OFFENSE**. DEPARTMENT OF MOTOR VEHICLES PRINTOUTS ARE **NOT** ACCEPTED IN LIEU OF COMPLETING THIS SECTION.

A. DATE OF ARREST: _____ B. CITY AND STATE WHERE ARRESTED: _____

C. NAME AND LOCATION OF COURT WHERE CASE WAS HEARD (IF APPLICABLE): _____

D. DETAILS OF THE VIOLATION OF WHICH YOU WERE CONVICTED (attach additional pages if necessary): _____

E. DATES OF IMPRISONMENT: _____ F. AMOUNT OF FINE PAID: _____

G. PERIOD OF PROBATION: _____

H. CONDITIONS OF PROBATION: _____

I. NAME AND ADDRESS OF PROBATION OFFICER: _____

8. IF YOU ANSWERED **YES** TO ITEM 7, YOU **MUST** PROVIDE **ALL OF THE INFORMATION** REQUESTED BELOW FOR **EACH OFFENSE**. DEPARTMENT OF MOTOR VEHICLES PRINTOUTS ARE **NOT** ACCEPTED IN LIEU OF COMPLETING THIS SECTION.

A. DATE OF ARREST: _____ B. CITY AND STATE WHERE ARRESTED: _____

C. NAME AND LOCATION OF COURT WHERE CASE WAS HEARD (IF APPLICABLE): _____

D. DETAILS OF THE VIOLATION OF WHICH YOU WERE CONVICTED (attach additional pages if necessary): _____

E. DATES OF IMPRISONMENT: _____ F. AMOUNT OF FINE PAID: _____

G. PERIOD OF PROBATION: _____

H. CONDITIONS OF PROBATION: _____

I. NAME AND ADDRESS OF PROBATION OFFICER: _____

*** SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT -**

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c)(2)(C))] authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

Notice to individuals (civ. Code, sec. 1798.17) – all items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information requested will be used to determine qualifications for examination and/or registration under the California Vocational Nurse Practice Act or California Psychiatric Technicians Law. The official responsible information maintenance is the executive officer at the above noted address and telephone number. Individuals have the right to review the files or records maintained on them by this agency, unless the records are identified as confidential information and exempted by section 1798.40 of the civil code. Information contained in your application may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties.



Notice on Collection of Personal Information For Applicants and Licensees

Collection and Use of Personal Information. The Board of Vocational Nursing and Psychiatric Technicians (BVNPT) of the Department of Consumer Affairs (DCA) collects the personal information requested on this form as authorized by Business and Professions Code Section 30 (General Provisions); Business and Professions Code Division 2, Chapter 6.5, Articles 1 & 2 (Vocational Nursing Practice Act) and Chapter 10, Articles 1 & 2 (Psychiatric Technicians Law); and California Code of Regulations Title 16, Division 25, Chapter 1 (Vocational Nurses) and Chapter 2 (Psychiatric Technicians). The BVNPT uses this information principally to identify and evaluate applicants for licensure, issue and renew licenses, and enforce licensing standards set by law and regulation.

Mandatory Submission. Submission of the requested information is mandatory. The BVNPT cannot consider your application for licensure or renewal unless you provide all of the requested information.

Access to Personal Information. You may review the records maintained by the BVNPT that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. The BVNPT makes every effort to protect the personal information you provide. The information you provide, however, may be disclosed in the following circumstances:

- In response to a Public Records Act request (Government Code Section 6250 and following), as allowed by the Information Practices Act (Civil Code Section 1798 and following);
- To another government agency as required or permitted by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

Contact Information. For questions about this notice or access to your records, you may contact the BVNPT at 2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833, (916) 263-7800 or email bvnpt@dca.ca.gov.