BOARD OF VOCATIONAL NURSING
AND PSYCHIATRIC TECHNICIANS
2535 CAPITOL OAKS DRIVE, SUITE 205
SACRAMENTO, CALIFORNIA 95833-2945
TELEPHONE (916) 263-7800; FAX (916) 263-7855
INTERNET ADDRESS: http://www.bvnpt.ca.gov

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 California Vocational Nurse 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 it 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 documentation:

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 $75.00 made payable to the "BVNPT". This is a nonrefundable 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 $56.00 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 stamp on the postcard to receive verification that your application was received by the Board.

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 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 documentation listed in Step #1.**
- **Record of Nursing Program** (Form 55A-2), Send this form to your school of practical/vocational nursing. This information will **not** be accepted unless your school of nursing mails it directly to the Board.

Method #3 – Equivalent Education and/or Experience.

- **Submit all documentation listed in Step #1.**
- **In addition, you must complete the following procedures:**

  - **Record of Nursing Program** (Form 55A-2) – Send this form to your school of practical/vocational nursing (if applicable). This information will **not** be accepted unless your school of nursing mails it directly to the Board.
  - **Record of Nursing Experience** (Form 55A-3) – Complete this form in full.
  - **Proof of 54 Theory Hours of Pharmacology** – You **must** submit proof of completion. Verification of 54 theory hours of pharmacology may be submitted on the Record of Nursing Program by the Director of Nursing, **or** a copy of your completion certificate specifying completion of 54 theory hours of pharmacology **and grade** is acceptable. **(See Summary of Requirements for required course content.)**

Method #4 – Military Applicants.

- **Submit all documentation listed in Step #1.**
- **Record of Military Service** (Form 55A-4)**.** Complete this form in full.
- **In addition, you must submit:**
  1. Copies of evaluations while assigned to a military hospital, or an original statement from a supervisor on military letterhead verifying **bedside patient care** (including dates and wards assigned).
  2. Proof of completion of a basic course in nursing in the armed forces.
  3. Proof of honorable discharge (DD214 or Certificate).

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 office 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 must be mailed directly to the Board from the school.
- Only official transcripts are acceptable (photocopies are not accepted.) Official transcripts **must** list subjects and hours (theory and clinical) completed for each subject area. Foreign transcripts **must** be accompanied by a certified translation if not in English.

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 Evaluation Fee	$75.00

FINGERPRINT PROCESSING FEES

FBI Fingerprint Card Processing Fee	$24.00
DOJ Fingerprint Card Processing Fee	$32.00
	$56.00**

[Note: If you will be submitting the "hard card" fingerprints rather than live scan fingerprints, you must include the $56.00 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 APPLICATION FOR LICENSURE BY EXAMINATION FEE

Application Processing Fee	$75.00**

(**Note: Retake applicants are not required to submit fingerprint cards and the applicable processing fees unless they have not previously satisfied this requirement. Applicants are only required to submit the fingerprint cards and processing fees one time.)

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.

NCLEX® Registration Fee – Registration by Mail	$200.00
NCLEX® Registration Fee – Registration by Telephone	$200.00

(VISA, MasterCard or American Express Required.)

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

- Applications will be accepted on a year-round basis. There are no specific filing deadlines. However, appointments for testing will be 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 6-8 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 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. Telephone registration fee is $200.00.

Registration by Internet

a. For internet registration, go to www.vue.com/nclex, and follow the instructions provided. Internet 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.

- Selecting 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 with forty-five (45) days of their requested test date.

- Failing candidates may retake the exam no more than once every 3 months.

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)) 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 judgement 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 or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.***

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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. MINIMUM AGE – 17 YEARS
2. COMPLETION OF THE 12TH GRADE OF SCHOOLING OR ITS EQUIVALENT (FURNISH PROOF).
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. 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.***
6. 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".)
7. SUCCESSFUL COMPLETION OF A WRITTEN EXAMINATION TITLED "THE NATIONAL COUNCIL LICENSING EXAMINATION FOR PRACTICAL (VOCATIONAL) NURSING (NCLEX)" 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.
8. WHEN THE REQUIREMENTS OF STEPS 1-7 HAVE BEEN MET, 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.

SUCCESSFUL COMPLETION OF 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 BEDSIDE NURSING EXPERIENCE IN A GENERAL ACUTE CARE FACILITY**, AT LEAST HALF OF WHICH SHALL HAVE BEEN WITHIN FIVE (5) YEARS PRIOR TO THE DATE OF APPLICATION. YOU MUST ALSO COMPLETE A PHARMACOLOGY COURSE OF AT LEAST 54 THEORY HOURS.

A. PHARMACOLOGY COURSE (54 THEORY HOURS)

- 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
- 5 WEEKS MATERNITY OR GENITOURINARY NURSING
- 5 WEEKS PEDIATRIC NURSING

C. EXPERIENCE IN ANY OF THE FOLLOWING AREA 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
- SKILLED OR LONG TERM NURSING CARE
- PRIVATE DUTY NURSING (IN A GENERAL ACUTE CARE FACILITY)
- EMERGENCY ROOM NURSING
- OUT PATIENT CLINIC
- POST ANESTHESIA RECOVERY NURSING
- HEMODIALYSIS NURSING
- REHABILITATION NURSING

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
- CATHETER CARE
- COLLECTION OF SPECIMENS
- DIABETIC URINE TESTING
- ADMINISTRATION OF A CLEANSING ENEMA
- FEEDING PATIENT
- INTAKE AND OUTPUT
- PERSONAL HYGIENE AND COMFORT MEASURES
- POSITIONING AND TRANSFER
- RANGE OF MOTION
- SKIN CARE
- VITAL SIGNS
- HOT AND COLD APPLICATIONS

2. **INFECTION 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. PROOF OF HAVING AT LEAST TWELVE (12) MONTHS SERVICE ON ACTIVE DUTY IN THE MEDICAL CORPS OF ANY OF THE ARMED FORCES RENDERING BEDSIDE PATIENT CARE. THE PROOF SUBMITTED MUST SHOW THE DATE(S), WARDS ASSIGNED, AND THE DUTIES PERFORMED.

B. PROOF OF HAVING COMPLETED A BASIC COURSE OF INSTRUCTION IN NURSING WHILE IN THE ARMED FORCES.

C. PROOF THAT SERVICE WAS UNDER HONORABLE CONDITIONS (DD-214).

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.

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

APPLICATION FOR VOCATIONAL NURSE LICENSURE

(ATTACH $75 APPLICATION FEE. AN ADDITIONAL $56 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.

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 (Mo/Day/Year)

5. SOCIAL SECURITY NUMBER**

6. TELEPHONE NUMBER
Business ( )_____
Home ( )_____
Area Code

7. DID YOU GRADUATE FROM HIGH SCHOOL? ☐YES ☐NO If "NO", Circle The Highest Grade You Completed 1 2 3 4 5 6 7 8 9 10 11 12

DID YOU PASS A HIGH SCHOOL "EQUIVALENCY" TEST? ☐YES ☐NO

NAME OF THE HIGH SCHOOL ATTENDED:_____ CITY/STATE:_____

8. DID YOU "ATTEND" A VOCATIONAL/PRACTICAL NURSING PROGRAM? ☐YES ☐NO DID YOU GRADUATE FROM THE PROGRAM? ☐YES ☐NO

IF YES, NAME OF VOCATIONAL/PRACTICAL NURSING PROGRAM: DATE STARTED: DATE COMPLETED: STATE OR COUNTRY:

9. DID YOU "ATTEND" A REGISTERED NURSING PROGRAM? ☐YES ☐NO DID YOU GRADUATE FROM THE PROGRAM? ☐YES ☐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? ☐YES ☐NO DATE LICENSED: STATE OF "ORIGINAL" LICENSURE:

11. HAVE YOU EVER BEEN LICENSED AS A REGISTERED NURSE? ☐YES ☐NO DATE LICENSED: STATE OF "ORIGINAL" LICENSURE:

12. HAVE YOU EVER APPLIED TO THIS BOARD FOR LICENSURE UNDER A DIFFERENT NAME? ☐YES ☐NO
IF "YES", PLEASE LIST OTHER NAMES:

WILL DOCUMENTS BE SUBMITTED TO THIS BOARD UNDER A DIFFERENT NAME? ☐YES ☐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 DENAIL OF LICENSURE.

14. **PHOTOGRAPH REQUIREMENTS:** YOU MUST ATTACH A CURRENT, FRONT VIEW, HEAD AND SHOULDER PHOTOGRAPH OF YOURSELF IN A SEALED ENVELOPE. THE PHOTOGRAPH SHOULD BE 2" X 2" AND MUST 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 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 or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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RECORD OF NURSING PROGRAM

The applicant listed below indicates that he/she attended your nursing program. Please complete the information below 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? ☐ YES ☐ 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? ☐ YES ☐ NO

9. COMPLETION OF THE TWELFTH (12TH) GRADE IN HIGH SCHOOL OR ITS EQUIVALENT HAS BEEN PROVEN BY THE APPLICANT AS FOLLOWS:

☐ PRESENTED OFFICIAL SCHOOL RECORDS SHOWING COMPLETION OF 12TH GRADE HIGH SCHOOL

☐ PASSED THE "GED" TEST AT THE 12TH GRADE LEVEL

10. A. TOTAL NUMBER OF THEORY/CLINICAL HOURS COMPLETED IN ***YOUR*** 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.*

SIGNATURE OF PROGRAM DIRECTOR:_____

(SCHOOL SEAL)

PRINT PROGRAM DIRECTOR'S NAME:_____

DATE:_____

RECORD OF NURSING PROGRAM

THE SECTION OF THIS FORM MUST BE COMPLETED IN FULL.

1. NAME OF SCHOOL OF NURSING CHECK ONE: ☐ VOCATIONAL/PRACTICAL NURSING PROGRAM ☐ REGISTERED NURSING PROGRAM	2. CITY	3. STATE AND COUNTRY
4. DATE PROGRAM STARTED (MONTH/DAY/YEAR)	5. DATE VERIFIED HOURS WERE COMPLETED (MONTH/DAY/YEAR)	

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							
NUTRITION							
PHARMACOLOGY							
NURSING FUNDAMENTALS							
MEDICAL-SURGICAL NURSING							
PSYCHOLOGY							
NORMAL GROWTH & DEVELOPMENT							
PEDIATRIC NURSING							
MATERNITY NURSING							
NURSING PROCESS							
COMMUNICATION							
PATIENT EDUCATION							
COMMUNICABLE DISEASES							
GERONTOLOGICAL NURSING							
REHABILITATION NURSING							
LEADERSHIP							
SUPERVISION							
TOTAL HOURS:							

55A-2 (11/03)

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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 your experience record for the past ten (10) years beginning with your most recent employment. Please be sure that the addresses given are complete and accurate. The Board will write to each of the employers you list below.

7A. Name of Hospital, Registry or Health Agency: _____ Address:_____ Telephone Number: ( )_____ Name of Supervisor (Physician/Registered Nurse): _____ Your name while employed at this facility: _____	Type of Duty: General Private Type of Patient Care for: Medical Surgical Maternity Pediatric Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year Total Amount of Time: _____ Years Months	*THIS SPACE FOR OFFICE USE ONLY*
7B. Name of Hospital, Registry or Health Agency: _____ Address:_____ Telephone Number: ( )_____ Name of Supervisor (Physician/Registered Nurse): _____ Your name while employed at this facility: _____	Type of Duty: General Private Type of Patient Care for: Medical Surgical Maternity Pediatric Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year Total Amount of Time: _____ Years Months	
7C. Name of Hospital, Registry or Health Agency: _____ Address:_____ Telephone Number: ( )_____ Name of Supervisor (Physician/Registered Nurse): _____ Your name while employed at this facility: _____	Type of Duty: General Private Type of Patient Care for: Medical Surgical Maternity Pediatric Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year Total Amount of Time: _____ Years Months	

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

Date:_____ Signature:_____

7D. Name of Hospital, Registry or Health Agency: _____ Address:_____ _____ _____ Telephone Number: ( )_____ Name of Supervisor (Physician/Registered Nurse): _____ Your name while employed at this facility: _____	Type of Duty: General Private Type of Patient Care for: Medical Surgical Maternity Pediatric Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year Total Amount of Time: _____ Years Months	*THIS SPACE FOR OFFICE USE ONLY*
7E. Name of Hospital, Registry or Health Agency: _____ Address:_____ _____ _____ Telephone Number: ( )_____ Name of Supervisor (Physician/Registered Nurse): _____ Your name while employed at this facility: _____	Type of Duty: General Private Type of Patient Care for: Medical Surgical Maternity Pediatric Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year Total Amount of Time: _____ Years Months	
7F. Name of Hospital, Registry or Health Agency: _____ Address:_____ _____ _____ Telephone Number: ( )_____ Name of Supervisor (Physician/Registered Nurse): _____ Your name while employed at this facility: _____	Type of Duty: General Private Type of Patient Care for: Medical Surgical Maternity Pediatric Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year Total Amount of Time: _____ Years Months	
7G. Name of Hospital, Registry or Health Agency: _____ Address:_____ _____ _____ Telephone Number: ( )_____ Name of Supervisor (Physician/Registered Nurse): _____ Your name while employed at this facility: _____	Type of Duty: General Private Type of Patient Care for: Medical Surgical Maternity Pediatric Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year Total Amount of Time: _____ Years Months	
7H. Name of Hospital, Registry or Health Agency: _____ Address:_____ _____ _____ Telephone Number: ( )_____ Name of Supervisor (Physician/Registered Nurse): _____ Your name while employed at this facility: _____	Type of Duty: General Private Type of Patient Care for: Medical Surgical Maternity Pediatric Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year Total Amount of Time: _____ Years Months	

** **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 or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
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INTERNET ADDRESS: http://www.bvnpt.ca.gov

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 OF EXECUTION OF SENTENCE WAS SUSPENDED
- ANY OFFENSE IN WHICH AN ORDER OF REHABILIATION 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. DATES OF 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 PSYHIATRIC 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 herein provided is true and correct. False statements included in this application can result in licensure denial.*

SIGNATURE:_____ DATE:_____

7. **ADDITIONAL INFORMATION** (CONTINUED FORM 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 $500*.
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. DATES OF PERIOD OF PROBATION:_____

H. CONDITIONS OF PROBATION:_____

I. NAME AND ADDRESS OF PROBATION OFFICER:_____

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H. CONDITIONS OF PROBATION:_____

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

G. DATES OF PERIOD OF PROBATION:_____

H. CONDITIONS OF PROBATION:_____

I. NAME AND ADDRESS OF PROBATION OFFICER:_____

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.

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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 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 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 Board of Vocational Nursing and Psychiatric Technicians, 2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833, (916) 263-7800 or email bvnpt@dca.ca.gov. For questions about the Department of Consumer Affairs' privacy policy or the Information Practices Act, you may contact the Office of Privacy Protection in the Department of Consumer Affairs, 400 R Street, Sacramento, CA 95814, (866) 785-9663 or email privacy@dca.ca.gov.