



# Board of Nursing

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

## CRITERIA FOR ADVANCED PRACTICE CERTIFICATION & INSTRUCTIONS FOR THE APPLICANT

- 1) Based on your RN licensure status, provide the following information to the Maryland Board of Nursing:

<i>If you have or ever had a Maryland RN number—whether it is current, inactive or non-renewed—submit the following:</i>	<i>If you have a Current Compact State RN License, submit:</i>	<i>If you have neither a current Maryland nor a Compact State RN license, submit the following:</i>
<ul style="list-style-type: none"> <li>• If inactive or non-renewed, please reactivate your Maryland RN number (unless you are living in a Compact state)</li> <li>• Certification application</li> <li>• Declaration of residence form</li> <li>• Sealed official transcript(s)</li> <li>• Copy of current national certification</li> <li>• <b>For Nurse Practitioners Only: Effective October 1, 2015:</b> If you have never been certified in Maryland or any other state you are required to have a Mentor for 18 months from the date of application. Your Mentor must be a Maryland licensed Nurse Practitioner or Physician with a license in good standing for at least three years.</li> </ul>	<ul style="list-style-type: none"> <li>• Certification application</li> <li>• Copy of Compact license</li> <li>• Declaration of residence form</li> <li>• Sealed official transcript(s)</li> <li>• Copy of current national certification</li> <li>• <b>For Nurse Practitioners Only: Effective October 1, 2015:</b> If you have never been certified in Maryland or any other state you are required to have a Mentor for 18 months from the date of application. Your Mentor must be a Maryland licensed Nurse Practitioner or Physician with a license in good standing.</li> </ul>	<ul style="list-style-type: none"> <li>• Application for licensure by endorsement (<a href="https://license.mdbon.org/NETS/Home.asp">https://license.mdbon.org/NETS/Home.asp</a>)</li> <li>• Certification application</li> <li>• Declaration of residence form</li> <li>• Sealed official transcript(s)</li> <li>• Copy of current national certification</li> <li>• <b>For Nurse Practitioners Only: Effective October 1, 2015:</b> If you have never been certified in Maryland or any other state you are required to have a Mentor for 18 months from the date of application. Your Mentor must be a Maryland licensed Nurse Practitioner or Physician with a license in good standing for at least three years.</li> </ul>

- 2) Complete a separate application for each certification you are applying for in its entirety.
- 3) If you are applying based on a compact state RN or if you have a MD RN and have not completed a background check for the MBON within the last 12 months, you must obtain a background check and attach a copy of the fingerprint card to your application prior to mailing the card to the Criminal Justice Information System Agency. If you are in MD please attach a copy of your receipt to your application.
- 4) If currently licensed in a Compact State, attach a copy of your current registered nurse license.

**NOTE:** *A Compact license means you are declaring the state in which you live as your permanent residence and that state is part of the Nurse Licensure Compact. For example, if you reside in Virginia and hold a Virginia Compact license, you will provide a copy of your Virginia RN license with your NP application.*

- 5) If applying for RN licensure by Endorsement:



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- a) Follow the instructions for “Online Initial Applications” available on the MBON web site or click the following link: <http://mbon.maryland.gov/Pages/olinitis-index.aspx>.
  - b) Request verification of your initial licensure by examination via NURSYS or the original state of RN licensure. The URL link to NURSYS is as follows: <https://www.nursys.com/NLV/NLVTerms.aspx>.
  - c) Obtain fingerprints through the Criminal Information Justice System (CJIS). Instructions for obtaining fingerprints are included in the online instructions.
- 6) Have your school mail an official sealed final transcript from your nurse practitioner program or have them sent electronically to: [mbon.advpracttranscripts@maryland.gov](mailto:mbon.advpracttranscripts@maryland.gov).
- NOTE:** *If you attended more than one school to become an NP you must submit an official transcript from each program.*
- a) Your transcript(s) must show proof of having completed the following along with other course work.
    - i) Advanced Pharmacology
    - ii) Advanced Pathophysiology
    - iii) Advanced Physical Assessment
- 7) All advanced practice programs must be approved by the Maryland Board of Nursing. If your program has not been approved your application will not be processed until approval has been obtained. A list of approved programs may be viewed on our website at: <http://mbon.maryland.gov/Documents/approved-np-programs.pdf>.
- NOTE:** *If your school's name, program title, and degree type does not appear on the approved list, please have your school complete a NP Program Approval Application ([http://mbon.maryland.gov/Documents/program\\_approval\\_form.pdf](http://mbon.maryland.gov/Documents/program_approval_form.pdf)) to have it added to our approved list and email it to: [mbon.educationprograms@maryland.gov](mailto:mbon.educationprograms@maryland.gov).*
- 8) **Effective October 1, 2015:** If you have never been certified in Maryland or any other state you are required to have a Mentor for 18 months from the date of application. Your Mentor must be a licensed Nurse Practitioner or Physician in Maryland for at least three years in good standing.
  - 9) Review the following page of certifications approved by the Maryland Board. Attach a copy of your current national certification certificate or your letter of eligibility if you are applying for Graduate NP status.
  - 10) If applying for Graduate CRNP/APRN status, you need to complete the GRADUATE AGREEMENT please *click here to access the Graduate Supervision forms:* [http://mbon.maryland.gov/Documents/graduate\\_agreement.pdf](http://mbon.maryland.gov/Documents/graduate_agreement.pdf)
  - 11) Submit the **\$50.00** non-refundable application fee for initial CRNP/APRN certification or **\$25.00** for each additional area of NP certification via mail or at in the lobby. Make your check or money order payable to the Maryland Board of Nursing.
  - 12) Allow approximately 2 – 4 weeks for processing. Incomplete applications will require additional processing time.



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## **NATIONAL CERTIFICATION BOARDS AND EXAMINATIONS ACCEPTED BY THE MARYLAND BOARD OF NURSING**

The Maryland Board of Nursing currently accepts the following national certification examinations for Advanced Practice specialties. Certification from Boards other than the following will not qualify you for certification as an Advanced Practice Registered Nurse in Maryland.

**ANCC**

American Nurses Credentialing Center

**AACN**

American Association of Critical Care Nurses

**AANP**

American Academy of Nurse Practitioners

**NBCRNA**

National Board of Certification and Recertification for Nurse Anesthetists

**ONCC**

Oncology Nurses Certification Corporation

**AMCB**

American Midwifery Board

**PNCB**

Pediatric Nursing Certification Board

**NCC**

National Certification Corporation



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## MARYLAND BOARD OF NURSING APPLICATION FOR ADVANCED PRACTICE CERTIFICATION

**NON-REFUNDABLE APPLICATION FEE: \$50.00 (check or money order)**

I hereby make application for certification to practice as an Advanced Practice Registered Nurse in the State of Maryland in accordance with the Maryland Annotated Code, Health Occupations Article, Section 8-205 and the Regulations Governing the Practice of Nurse Practitioners (10.27.07) and submit the following evidence of my qualifications for certification.

<b>NAME:</b>			
	LAST	FIRST	MIDDLE OR MAIDEN

<b>ADDRESS:</b>	
NUMBER AND STREET (UNLESS THE ADVANCED PRACTICE DEPARTMENT RECEIVES WRITTEN NOTIFICATION OF A CHANGE OF ADDRESS, ALL CORRESPONDENCE ASSOCIATED WITH THIS APPLICATION WILL BE MAILED TO THE ABOVE ADDRESS.)	

CITY		STATE	ZIP CODE

MARYLAND RN LICENSE #: _____ <input type="checkbox"/> PENDING	DATE OF BIRTH: _____	SOCIAL SECURITY #: ____ - ____ - ____
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<b>WORK TELEPHONE:</b>		<b>HOME/CELL TELEPHONE:</b>	
<b>E-MAIL ADDRESS:</b>			

<b>DISCIPLINE:</b> HAVE YOU EVER BEEN CONVICTED OF OR PLEAD GUILTY OR NOLO CONTENDERE (THIS INCLUDES A GUILTY PLEA FOR WHICH A PBJ WAS RECEIVED):	
TO A MISDEMEANOR?	<input type="checkbox"/> YES <input type="checkbox"/> NO
TO A FELONY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
OR HAD ANY DISCIPLINARY ACTION TAKEN AGAINST YOUR LICENSE IN ANY STATE?	<input type="checkbox"/> YES <input type="checkbox"/> NO



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## BACKGROUND

1. Have you ever pleaded guilty or nolo contendere (i.e., “no contest”) to (this includes a guilty plea for which probation before judgment was received), or ever been convicted of any criminal act (excluding minor traffic violations)?

Yes  No

2. Have you ever been convicted of or pled guilty to, in any civil, administrative, or criminal proceeding, the possession, use, manufacture, distribution, or diversion of controlled substances or prescription drugs?

Yes  No

3. Have you ever had any application, license, certificate, permit or other privilege to practice any health care occupation:

a. Denied?

Yes  No

b. Disciplined, including, but not limited to, reprimand, censure, fine, surrender, probation, suspension, or revocation?

Yes  No

4. With respect to any application, license, certificate, permit or other privilege to practice any health care occupation, have you ever been placed in a non-disciplinary probation, monitoring, practice remediation, or other similar program?

Yes  No

For Questions 2 and 3:

a. A detailed letter of explanation; AND

b. Official copies of any documentation, including disciplinary orders, issued by a regulatory body regarding the denial or discipline of any application, license, certificate, permit or other privilege to practice any health care occupation, or any documentation regarding non-disciplinary probation, monitoring, practice remediation, or another similar program.

5. Have you ever surrendered or allowed your license/certificate to lapse while under investigation by any licensing or disciplinary board or any jurisdiction, including Maryland?

Yes  No

If you answered “Yes” to any of the previous questions, you must submit the following:

For Questions 17 and 17A:

a. A detailed letter of explanation, including the circumstances surrounding the crime, the date of your conviction or plea, the crime of which you were convicted or to which you pled guilty, your sentence, if and when you completed your sentence, and any other information you would like the Board to consider, such as subsequent work history, what you have learned, etc.; AND

b. Court certified or true-test copies of court documents regarding the facts and circumstances of the crime, your plea(s) or the disposition of your charge(s), the sentence imposed, and current status of your sentence (i.e., all fines paid in full, completion letter from Parole/Probation Officer, etc.), or a letter/form from the court indicating that no records are available. Examples of court documents that show facts and circumstances surrounding the crime include statement of probable cause/application for statement of charges, arrest affidavit, or plea agreement.

For Question 17D: A detailed letter of explanation.

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Signature

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Date



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**ADVANCED PRACTICE CERTIFICATION TYPE(S) APPLYING FOR:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> PEDIATRIC PRIMARY CARE                 | <input type="checkbox"/> PSYCHIATRIC MENTAL HEALTH    | <input type="checkbox"/> GERIATRIC                 |
| <input type="checkbox"/> PEDIATRIC ACUTE CARE                   | <input type="checkbox"/> FAMILY                       | <input type="checkbox"/> ACUTE CARE                |
| <input type="checkbox"/> ADULT GERONTOLOGY PRIMARY CARE         | <input type="checkbox"/> NEONATAL                     | <input type="checkbox"/> CERTIFIED NURSE MIDWIFE   |
| <input type="checkbox"/> ADULT GERONTOLOGY ACUTE CARE           | <input type="checkbox"/> OB/GYN                       | <input type="checkbox"/> CLINICAL NURSE SPECIALIST |
| <input type="checkbox"/> CERTIFIED REGISTERED NURSE ANESTHETIST | <input type="checkbox"/> PSYCHOTHERPIST MENTAL HEALTH | <input type="checkbox"/> ADULT                     |

**ATTACH** A COPY OF YOUR CURRENT NATIONAL CERTIFICATION OR RECERTIFICATION

**ADVANCED PRACTICE REGISTERED NURSE PROGRAM**

**HAVE OFFICIAL SEALED TRANSCRIPTS MAILED DIRECTLY TO MBON AT THE ADDRESS BELOW OR SENT ELECTRONICALLY TO: [mbon.advpractranscripts@maryland.gov](mailto:mbon.advpractranscripts@maryland.gov).**

NAME OF SCHOOL:		
ADDRESS: CITY, STATE, ZIP:		
DEGREE OR CERTIFICATE CONFERRED:	YEAR OF GRADUATION OR DATE OF COMPLETION:	
<input type="checkbox"/> MASTERS <input type="checkbox"/> POST-MASTERS <input type="checkbox"/> DNP		

**For Nurse Practitioners Only:**

Have you been certified as a Nurse Practitioner in this state or any other state?  YES  NO

If the answer is "No," Code of Maryland (COMAR) regulation 10.27.07.03.B(3)(c) of the Nurse Practice Act requires you to have a designated mentor for 18 months from the date of this application. Your mentor must be a physician or nurse practitioner with a Maryland license in good standing with three (3) or more years of clinical experience. If you have not been certified as a Nurse Practitioner for at least 18 months, or have never been licensed in any state, please provide your mentor's name and Maryland license number below.

MENTOR'S NAME: \_\_\_\_\_ LICENSE NUMBER: \_\_\_\_\_

I (TYPE LEGAL NAME) \_\_\_\_\_ hereby declare and affirm that all information I have provided on this form is true and complete to the best of my knowledge, information, and belief. (Providing false or misleading information may result in disciplinary action by the Board.)

SIGNATURE:	DATE:



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## DECLARATION OF RESIDENCE FOR ADVANCED PRACTICE

PLEASE RETURN COMPLETED FORM WITH YOUR ORIGINAL SIGNATURE  
TO THE MARYLAND BOARD OF NURSING

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(CURRENT MAILING ADDRESS)

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

Nursing License Number: \_\_\_\_\_ ISSUING STATE: \_\_\_\_\_

I DECLARE THAT \_\_\_\_\_ IS MY LEGAL STATE OF RESIDENCE

\_\_\_\_\_  
ORIGINAL SIGNATURE AND DATE

ENCLOSE A COPY OF YOUR STATE ISSUED ID OR DRIVER'S LICENSE FOR  
PROOF OF RESIDENCY

**YOUR ID MUST MATCH THE STATE YOU DECLARE AS YOUR PRIMARY STATE OF RESIDENCE.**

**IF YOU ARE MILITARY OR A MILITARY SPOUSE, PLEASE ALSO INCLUDE A COPY OF YOUR MILITARY  
2058 FORM FOR PROOF OF RESIDENCE.**

MAIL TO:  
MARYLAND BOARD OF NURSING  
ADVANCED PRACTICE UNIT  
4140 PATTERSON AVENUE  
BALTIMORE, MD 21215