Colorado Division of Professions and Occupations

Office of Licensing—Nursing

1560 Broadway, Suite 1350 Denver, CO 80202

Phone: (303) 894-7800 / Fax: (303) 894-7693

www.dora.colorado.gov/professions

REINSTATEMENT APPLICATION—REGISTERED NURSE

APPLICANT INSTRUCTIONS

Only complete this application if your Colorado RN license is in Expired status. If your license is in Inactive status, you must complete a Reactivation application.

Nurse Licensure Compact. The Nurse Licensure Compact became effective in Colorado on October 1, 2007, allowing nurses licensed in Colorado to practice in other compact states. A nurse may hold only one compact license and it must be issued by his/her state of primary residence. If you declare your primary state of residence to be a compact state other than Colorado, you should not apply for licensure in Colorado and your application will be returned to you. Upon issuance of a Colorado multistate license, your other compact state license(s) will expire. You may be required to provide proof of residency, which may include but is not limited to a Colorado driver's license, voter registration or income tax return. If you declare a non-compact state as your state of primary residence, and you meet all other requirements for licensure in Colorado, you will receive a single-state license valid for practice only in Colorado. For a list of states participating in the Compact or for additional information regarding the Compact visit:

www.dora.colorado.gov/professions/nursing or https://www.ncsbn.org/nlc.htm.

Mandatory Practice Act. Colorado has a mandatory practice act, which means that you may not practice as a Registered Nurse in this state without a Colorado or other compact state license. Submission of this application does not guarantee licensure; therefore, do not make life or career decisions based on the probability that you may receive a license. Plan ahead for the time it will take to receive and review all required documents and complete our evaluation.

Basic Requirements. Requirements for licensure are outlined in the Colorado Revised Statutes, specifically 12-38-101, the Board's rules, and the Board's policies. These documents are available online at www.dora.colorado.gov/professions/nursing.

In compliance with the Michael Skolnik Medical Transparency Act of 2010, all applicants are required to complete and maintain an online Healthcare Professions Profile on our website at www.dora.colorado.gov/professions/hppp.

Retired Volunteer Nurse Status. You may apply for reinstatement as a Retired Volunteer Nurse if you are at least 55 years of age and you meet the competency requirements as outlined in Board Rule 5.6. You may not accept compensation for nursing tasks performed.

About the Application. This application is to be completed by you and returned to the Office of Licensing. All questions on the application are mandatory, and all supporting documents must be submitted with the application. The application forms must be completed in original ink or typed. Keep a copy of the completed application and supporting documents for your records.

Application Expiration. Your application will be kept on file for one (1) year from the date of receipt in the Division. Your file and all supporting documentation will be purged if you do not submit required documents and complete your application process in one year. You will need to submit a new application packet and fee after that time.

Social Security Number is Required. Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit his/her Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. The affidavit is available on our website at www.dora.colorado.gov/professions/nursing, or you may call (303) 894-7800 to request that one be mailed to you.

APPLICANT INSTRUCTIONS (Continued)

Disclosure of Addresses. Consistent with Colorado law, all addresses and phone numbers on record with the Division are public record and must be provided to the public when requested. It is your responsibility to keep your address, phone numbers and contact information up-to-date in our database. All letters, renewal notices, and licenses are mailed to the last known address of record. **If your address is not current, it is possible you will not receive important documents.** You can change your address online by using Online Services at www.dora.colorado.gov/professions/onlineservices.

License Expiration Grace Period for Applicants. Registered Nurse license expiration dates are September 30 of either odd-numbered years or even-numbered years, and are dependent upon the issuance date.

Checking Your Application Status. Visit Online Services at www.dora.colorado.gov/professions/onlineservices to track your application from the date we log it in our database to the date your license is printed. Please allow us enough time to receive the application through the mail and enter your application into our database before you check the website. We recommend waiting at least 10 business days from date of mailing before checking the status of your application.

Advanced Practice and Prescriptive Authority. Reinstatement of your RN license does not reinstate expired Advanced Practice and Prescriptive authorities you may have held at the time your RN license expired. You must submit separate authority(ies) reinstatement applications after your RN license is reinstated. Applications to reinstate your authorities are available online at www.dora.colorado.gov/professions/nursing.

APPLICANT CHECKLIST

To appl	y to reinstate your expired Colorado Registered Nurse license:
	Complete the attached application. Return the completed application and all supporting documentation to the Office of Licensing.
	Enclose the non-refundable application processing fee. See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to <i>State of Colorado</i> . All fees are non-refundable and subject to change every July 1.
	Complete and return the attached Affidavit of Eligibility form. Pursuant to C.R.S .24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.
	Provide documentation of any name change. If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).
	Complete an online Healthcare Professions Profile. Once your application is received and entered into the Division of Professions and Occupations database, you must create a Healthcare Professions Profile on our website at www.dora.colorado.gov/professions/hppp . You may begin checking the Healthcare Professions Profiling Program (HPPP) website within a few days of submitting your application. If you cannot create your profile within 14 days of submitting your application, or if you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at (303) 894-5942. Your application is not considered complete , and a license will not be issued until you have submitted the online profile.
	If your license has been expired for more than two years or you have not practiced as a registered nurse within the two (2) year period preceding your submission of this application, you must demonstrate competency to practice. Refer to the Competency to Practice section of the application for detailed instructions.

Return your completed application packet and all supporting documentation to:

Office of Licensing—Nursing
1560 Broadway, Suite 1350
Denver, CO 80202



Lauren Larson
Director, Division of Professions and
Occupations

IMPORTANT NOTICE

TO: All Applicants

FROM: Director of the Division of Professions and Occupations

SUBJECT: Licensure and Criminal History

Thank you for your interest in becoming a licensed* professional within the Division of Professions and Occupations. Before you submit your application, please be aware of a few facts regarding criminal conduct, convictions, and disciplinary actions in other states.

The mission of the Division of Professions and Occupations is "public protection through effective licensure and enforcement." One way the Division safeguards consumers is by issuing licenses to fully qualified, competent, and ethical applicants.

During the licensing process – and depending on the specific application – the Division may ask whether you have ever been disciplined in any state, arrested, charged, convicted, or pled guilty to a crime. An arrest, subsequent criminal conviction, or disciplinary action is not an automatic disqualification from licensure. Rather, the appropriate board or program will look at the facts surrounding the criminal conduct and disciplinary action in addressing your license application. You should know that licensure is a privilege, not a right. One thing you must do to obtain the privilege is to be complete and accurate in disclosing information on your application.

Be sure to list all relevant complaints, disciplinary actions, arrests, charges, or convictions in response to the appropriate licensure questions. Failure to fully and accurately disclose requested criminal history information, alone, could constitute grounds for denial of your application or revocation of your license. When requested, you must include information regarding prior conduct. This remains the case when the conduct is seemingly unrelated to the activities of a profession, and when the conduct involves deferred sentences or judgments.

Remember, even following licensure, you are still required to notify your professional licensing board or program about subsequent convictions and disciplinary actions in other states.

Please be aware that the Division conducts audits of its licensing database against several criminal and national disciplinary databases. This allows the Division to verify the truthfulness of your application and track subsequent criminal and disciplinary conduct after initial licensure. Keep in mind, your license will not necessarily be revoked, or your application denied, if you have been disciplined, arrested, charged or convicted. But, you will most likely be denied or revoked if you fail to disclose requested information.

*The word "license" is used as a general term. While most of the professions and occupations are licensed, others may be registered, certified, or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.



Colorado Department of Regulatory Agencies Division of Professions and Occupations 1560 Broadway, Suite 1350 Denver, CO 80202

Licensee/Applicant Full Legal Name

Last			First	Middle	Suffix		
	Colorado Professional or Occupational License/Certification/Registration Number: (if already licensed) Professional or Occupational License/Certification/Registration type applying for:						
			AFF	IDAVIT OF ELIGIBILIT	Y		
				LL applicants for original licer required to complete and sign		ng or reinstating a	
				of the professions and occupations a profession or occupation, please co			
		Sect	ion A: LA\	WFUL PRESENCE in the Un	ited States		
1.				cceptable secure and verifiab d. Complete documentation r			
2.	2. I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.						
3.	I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.) a. I am a U.S. citizen, not physically present or employed in the United States.						
	b. I am a Foreign National, not physically present or employed in the United States.						
		Coot	D. CE	CUDE AND VEDICIADI E DO	CLIMENTO		
	Section B: SECURE AND VERIFIABLE DOCUMENTS Select ONE document in this section if you checked 1 or 2 in Section A.						
		Name of state				Expiration	
Go	vernment Issued	or federal ag	ency that	Full name as shown on o		Date	
П	Identification Driver's license or	issued the d	ocument	license or state/federal is	sued ID Number	(mm/dd/yyyy)	
	permit						
	Government issued ID card						
	Valid U.S. military ID/common access card						
	Colorado Department of Corrections inmate ID						
	Tribal ID card						
	U.S. passport						
	Certificate of						

	Section B: SECURE	AND VERIFIABLE D	JCOINLINI 3 (COII	itiriueu <i>j</i>		
	Name of state agency				Expiration	
Government Issued	or federal agency that	Full name as shown on driver's		License/ID	Date	
Identification	issued the document	license or state/fe	deral issued ID	Number	(mm/dd/yyyy)	
Certificate of (U.S.) Citizenship						
☐ Valid Temporary Resident card						
Valid I-94 issued by Canadian government						
Valid I-94 with refugee/asylum stamp						
☐ Valid I-766 (Employ	ment Authorization Card)		Issuing federal a	agency:		
Name	on card	Alien Number (A#)	Card Number	Valid from (mm/dd/yyyy)	Expires (mm/dd/yyyy)	
☐ Valid I-551 (Reside	nt Alien or Permanent Resid	dent Card)	Issuing federal a	agency:		
Name	on card	Alien Number (A#)	Country of birth	Card expires (mm/dd/yyyy)	Resident since (mm/dd/yyyy)	
		,		((**************************************	
☐ Valid foreign passp	ort with an unexpired visa w	vith proper classification	n for work authoriza	ation, and an unex	pired I-94	
			Visa Class		1	
Issuing foreign country	Passport Number	Visa Number	(ex.: J-1, P-1, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)	
			, ,	(**************************************	(**************************************	
☐ Valid foreign passp visa	ort bearing an unexpired "P	rocessed for I-551" sta	mp or with an attac	ched unexpired "Te	emporary I-551"	
Issuing foreign countr	y:		Passport Number	er:		
Section C: ATTESTATION						
 I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence. 						
 I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the above statements are true and correct. 						
 I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit. 						
 I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification. 						
Print Full Legal Name						
Signature (Full Name)			Date			

Division of Professions and Occupations
Office of Licensing–Nursing
(303) 894-7800 / Fax (303) 894-7693
www.dora.colorado.gov/professions

Reinstatement Application REGISTERED NURSE

Active Status Fee: \$128

Retired Volunteer Nurse Status Fee: \$20

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

Fees may be paid by check or money order drawn in U.S. dollars on a U.S. bank and made payable to State of Colorado. Select a license status: ☐ I wish to reinstate with full **ACTIVE** status. Fee: **\$128** ☐ I wish to reinstate with **RETIRED VOLUNTEER NURSE** status. Fee: **\$20** (To be eligible for Retired Volunteer Nurse status, you must be 55 years of age or older, must meet the competency requirements outlined in Board Rule 5.6, and may not accept compensation for nursing tasks performed as a volunteer.) Colorado Registered Nurse License Number: Date License Expired: PART 1—APPLICANT INFORMATION Name: Last: First: Middle: Suffix: Previous Name(s): Social Security Number: * Date of Birth (mm/dd/yyyy): **Gender:** □ *Male* □ *Female* Place of Birth (city and state, or foreign country): PO Box, Street: **Mailing Address:** City, State, Zip: This is a Home Business **Daytime Telephone Number: (** E-mail Address: Preferred method for communication:

Mail

E-mail **PART 2—LICENSE INFORMATION** A. Since the date your Colorado nursing license expired, have you been practicing as a ☐ YES ☐ NO Registered Nurse in the state of Colorado? Do you hold an active Compact multi-state license? If YES, provide license information. ☐ YES ☐ NO Have you practiced on Disciplinary action Is this license this license in the past current/active? State **Issue Date Expiration Date** against license? 2 years? ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO B. List each jurisdiction, other than Colorado, in which you hold or have ever held any health care license. (If needed, attach an additional sheet using the same format.) If not applicable, enter N/A. Have you practiced on License Year license Disciplinary action Is this license this license in the past State/Country Type of license against license? current/active? Number issued 2 years? | YES | NO | | YES | | NO | YES | NO ☐ YES ☐ YES ☐ NO ☐ YES ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES

*Social Security Number Disclosure: Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's social security number. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support under § 14-14-113 and § 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation for identification purposes only. Your social security number will not be released for any other purpose not provided for by law.

APPLICANT NAME:	
APPLICANT NAME:	

	PART 3—MILITARY QUESTIONS		
1.	Are you a Member of the U.S. military?	☐ YES	□ №
	> If YES, provide information below:		
Bra	anch: Duty Station:		
2.	Are you the spouse of an active duty military member who has been relocated to Colorado and hold a currently valid and active credential to practice your profession in another state?	☐ YES	□NO
	If YES, refer to the Military Spouse Exemption Form available on our website at: www.dora.colorado.gov/professions/military.		
	PART 4—SCREENING QUESTIONS		
Yo	u must provide the following for each "YES" response to the screening questions below:		
	 An explanation, signed and dated by you, of your behavior or practice that led to the occurrence, Date(s) of event/offense Description of event/offense Location/court 	including:	
V-	Current status/outcome		
10	 u may be required to provide the following: Copies of legal documents relating to the event/offense. 		
	 Copies of legal documents indicating your compliance with any requirements imposed upon you. 		
1.	Has any nursing or other health care license held by you been denied, revoked, suspended, reprimanded, fined, surrendered, restricted, limited, or placed on probation in any state other than Colorado or in any territory of the United States?	☐ YES	□NO
2.	Are you under investigation or is a disciplinary action pending against your nursing license or other health care license in any state or territory of the United States?	☐ YES	□NO
3.	Have you received notification from the Department of Health and Human Services, Office of the Inspector General, that you have been excluded from participation in Medicare, Medicaid or any federal health care programs based on program related crimes and discipline?	☐ YES	□NO
4.	Have you ever been convicted, entered a plea of guilty, nolo contendere, or no contest for any felony, misdemeanor or petty offense?	☐ YES	□NO
5.	Have you ever been convicted, pled no contest/nolo contendere, or had a court accept a plea to a criminal motor vehicle offense of DUI/DWI/DWAI/OWI or any traffic offense involving drugs or alcohol?	☐ YES	□NO
6.	Has any final judgment, settlement or arbitration award for malpractice been paid by you or on your behalf?	☐ YES	□NO
7.	In the last five years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a professional nurse safely and competently including but not limited to bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder?	☐ YES	□NO
8.	Do you now abuse or excessively use, or have you in the last five years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a professional nurse safely and competently?	☐ YES	□NO

		APPLICANT NAME:	_				
PART 4—SCREENING QUESTIONS (Continued)							
ca	re position because of y	d or permitted to resign in lieu of termination from a nursing or other health \(\subseteq\) YES \(\subseteq\) No your use of alcohol or use of any controlled substance, habit-forming drug, or drugs having similar effects?	Э				
10. Ha	ve you been arrested fo	or an alcohol or drug-related offense other than stated in question No. 5?	0				
	F	PART 5—DECLARATION OF PRIMARY STATE OF RESIDENCE					
"Prima		e" is defined as the state of a person's declared fixed permanent and principal home for legal					
purpos	es; domicile. Documer	ntation of primary state of residence that may be requested will include but is not limited to:					
b.	Federal income tax returnal Military Form no. 2058 - W2 from US Government	ome address; lisplaying a home address; rn declaring the primary state of residence; state of legal residence certificate; or nt or any bureau, division or agency thereof indicating the declared state of residence. cles 2E, 4C, and 4D)					
Based resider		ve, I declare that the state of is my legal primary state o	f				
	My primary state of re	ecidence is currently in another compact state and I am in the process of moving to					
Colora	ido. I understand that i	esidence is currently in another compact state and I am in the process of moving to in order to complete the licensure process, I must provide proof of Colorado residency and a shing Colorado residency.					
Prima	ry Residence	Street:					
	cal Address:	City, State, Zip:					
(PO Box	es are not accepted)	oity, otato, Lip.					
PART 6—DECLARATION OF STATE(S) OF CURRENT PRACTICE							
Upon I	icensure in Colorado, I	may practice in the state(s) of (Attach additional sheets if necessary):					
Colora	do (strike through if not	applicable)					
							
	☐ I will practice exclusively at a government / military facility and am requesting a Colorado single-state license.						
PART 7—COMPETENCY TO PRACTICE							
Has your Colorado license been expired more than two (2) years?							
	NO. I <u>HAVE</u> practiced nursing within the two (2) year period preceding submission of this application. Part 7 is complete. Sign, date and submit your application to the Office of Licensing						
		cticed nursing within the two (2) year period preceding submission of this application. competency by checking Option B below and following the corresponding instructions.					
	YES. You must demon	nstrate competency by one of the following methods. Check either Option A or Option B below onding instructions.					
	(continued on next pag	ge)					

APPLICANT NAME:	
-----------------	--

PART 7—COMPETENCY TO PRACTICE (Continued)

This section – and all attached forms referenced in this section – applies only to individuals whose license has been expired for more than two (2) years or who has not practiced nursing within the two (2) year period preceding submission of this application. Competency to practice may be established by one of the following methods:

Check either Option A or Option B

- **A.** Demonstration of the active practice of nursing in another state, federal facility, or U.S. territory during the two (2) years preceding the filing of this reinstatement application. If you select this option, you are attesting that you have worked during the two (2) years preceding the submission of this application and you must submit the following with your application:
 - Verification of Active Licensure. Contact the state in which you hold an active license, or a license that has been expired less than two (2) years, to determine their fee and which of the verification forms you need to submit.
 - ► For participating states, you must apply for NURSYS Verification through the NURSYS website (a current list of participating states can be found at www.nursys.com) —OR—
 - ► For non-participating states, you must complete and submit a Request for Verification of Nursing License form (attached).

This process may take anywhere from two weeks to several months, depending on your circumstances and how quickly you submit the supporting documentation required. You can help speed this process by completing the application thoroughly, supplying all the required supporting documents, and responding quickly to requests for information made by staff.

-OR-

- **B.** Successfully completing refresher courses as defined in Nursing Board Rule 5.6. If you select this option, <u>you must complete all three of the following steps:</u>
 - 1. Register for a Board-approved nursing education program / refresher course.

П

2. Within the guidelines of your chosen program / course, locate a qualified clinical agency (acute, subacute, skilled) to obtain the required, unpaid supervised clinical experience. Submit a completed Non-Traditional/Refresher Program Instructor/Preceptor Agreement (attached) with your application and fee to the Office of Licensing, 1560 Broadway, Suite 1350, Denver, CO 80202.

Upon review and approval of the application and Non-Traditional/Refresher Program Instructor/Preceptor Agreement, your license will be reinstated in a Restricted Status, valid only for the purpose of completing the clinical experience. Plan ahead for the time it will take to receive and review all required documents and complete our evaluation.

This process must be completed prior to the start of the clinical training.

- 3. Upon completion of steps 1 and 2 above, provide evidence of having completed all requirements as follows:
 - Obtain an official transcript or certificate in its official sealed envelope indicating completion of the Boardapproved nursing education program/refresher course;
 - Obtain an original completed Non-Traditional/Refresher Program Skills Checklist (attached) from your Preceptor in an official sealed envelope; and
 - Submit both documents in their unopened, sealed envelopes to the Office of Licensing.

Upon review and approval of both documents, the restriction will be removed from your license and a new license copy will be issued in an Active or Retired Volunteer Status, as appropriate, if all other licensing requirements are met.

ATTESTATION	
I state under penalty of perjury in the second degree, as defined in C.R.S this application is true and correct to the best of my knowledge. In accor statements made herein are punishable by law and may constitute violat	rdance with C.R.S. 18-8-501(2)(a)(I), false
Applicant Signature	Date

APPLICANT NAME: __

USE THIS FORM IF YOUR STATE OF ACTIVE LICENSURE IS NOT LISTED WITH NCSBN/NURSYS

For a list of NURSYS participating states, please see www.nursys.com

Colorado Division of Professions and Occupations

Office of Licensing-Nursing

1560 Broadway, Suite 1350 Denver, CO 80202

Phone: (303) 894-7800 / Fax: (303) 894-7693 www.dora.colorado.gov/professions

REQUEST FOR VERIFICATION OF NURSING LICENSE

You are responsible for ensuring your state of licensure sends verification to the Colorado Office of Licensing.

You are also responsible for ensuring its receipt by the Colorado Office of Licensing.

PART 1: To be completed by the <u>APPLI</u> state.			
Last Name	First		Middle
Previous Name(s)			
Mailing Address (PO Box, Street, City, State, &	& ZIP)		
Social Security Number	Date	of Birth	
Licensed under the name of	Year of License		Original license number
I hereby authorize all Boards of	Nursing to release my license da	ata to the Colorado	Board of Nursing.
Applicant Signature		Date	
ART 2: To be completed by the <u>LICEN</u>	SING BOARD of the state of acti	ve licensure and s	ent to the Colorado (
of Licensing.			
icensed by Exam:	State Board Exam RN	NCLEX RN	
Score			
Series/Form			
icensed by Endorsement: State:			
Active License/Registration Number	Date Issued		License Expiration Date
as any disciplinary action EVER been taken a	gainst this license?	YES NO	
► If YES, please send certified co	pies of all disciplinary actions.		
license now in good standing?		YES NO	
► If NO , please attach documenta	tion.		
(Board Seal) Si	gnature		Title

NON-TRADITIONAL PROGRAM OR REFRESHER PROGRAM INSTRUCTOR / PRECEPTOR AGREEMENT All information requested in this form must be provided

Student Name (print legibly)	Colorado License Number			
This Agreement, by and between the Student, Instructor/Precept purpose of providing clinical experience to Student pursuant to Color 5.6, which is incorporated herein by reference. See <a and="" bon")="" co.us="" href="https://www.dora.state.com/w</td><td>rado State Board of Nursing (" licensure="" nursing="" of="" practical="" professional<="" pursuant="" rule="" rules="" rules,="" td="" to="">				
Instructor/Preceptor agrees to provide (circle one): (A) clinical instructor directly overseeing a small group of students –OR– (B) d Instructor/Preceptor agrees to evaluate Student's performance pursu Program Skills Checklist" and to provide student with the required exclinical portion of the refresher course. In addition, Instructor/Precept of completion and the original Non-Traditional/Refresher Program Sk student for submission to BON;	irect supervision of student on a 1:1 basis. uant to the BON "Non-Traditional/Refresher valuation upon Student's completion of the tor will provide official transcripts or certificate			
 NOTE: Instructor/Preceptor who signs this form mus signs the Skills Checklist. 	t be the same instructor/preceptor who			
Refresher Program Faculty agrees that its refresher program w Student in an official transcript or certificate of completion as require				
Non-Traditional Faculty agrees that its non-traditional program work to the Student in an official transcript as required by the <i>Chapte of Practical and Professional Nurses</i> ;				
Facility agrees that the clinical instruction required herein may b	e provided at its facility.			
INSTRUCTIONS FOR COMPLETING THIS FORM:				
Applicants for RN reinstatement should have sections 1, 2 and 3 bel	ow completed by your Instructor/Preceptor;			
Graduates of Non-Traditional RN nursing education programs should your Instructor/Preceptor:	d have sections 1 and 3 below completed by			
1. Instructor/Preceptor:				
Instructor/Preceptor signature	Date			
Printed Name:				
Title/Position: Phone number:				
License No(s): RN Status of	f License(s):			

Schools attended & years graduated: _____

State(s) licensed: _____ Year(s) Issued: ____ Exp. date(s): ____

Educational degrees: ______ Yrs. clinical experience: _____

2. Faculty: Faculty member signature		Date
Printed name of school:		
Address of school:		
Printed name of faculty member:		
Title:	E-mail address:	
Phone number:	Fax number:	
3. Facility:Facility representative sign.	ature	Date
Printed name of facility:		
Address of facility:		
Facility provides (circle all that apply): acute	e care sub-acute care	skilled nursing
Printed name of facility representative:		
Title:	E-mail address:	
Phone number:	Fax number:	
All Applicants must sign and date the form be	elow:	
4. Student:Student signature		
Student signature		Date

APPLICANT NAME:

NON-TRADITIONAL / REFRESHER PROGRAM Skills Checklist

Student	_ Social Security Number
Program	
Instructor/Preceptor	
Clinical Supervision Start Date	End Date

- Please mark each competency as 'Satisfactory,' 'Needs Improvement,' OR 'Not Observed'
 - > NOTE: All clinical competencies must be observed

Bold Items are emphasized for graduates of Non-Traditional RN Programs

Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
RN Provider Role	Catisiactory	Improvement	Obscived	mitiais
Performs a comprehensive patient assessment in order to establish a plan of care.				
Formulates a nursing plan of care with identified outcomes in collaboration with the patient, family and the health care team.				
Demonstrates use of a broad range of information, knowledge and skills; and critical thinking in the clinical decision-making processes when providing nursing care.				
Uses the nursing process, accepted practice standards, policies and procedures and established protocols when providing patient care.				
Delegates nursing functions appropriately.				
• Within the responsibility, knowledge, skill and ability of the RN delegating.				
 Routine, repetitive in nature and requires no nursing judgment or intervention. Limited to a specific delegatee, for a specific client, and within a specific time frame except for delegation (exception is for K12 school nursing) 				

Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
Administers prescribed treatments including	Satisfactory	improvement	Observed	IIIIIIIII
medications.				
Has accurate knowledge of the treatment procedure, rationale for the treatment, and expected outcome.				
Skilled in safely administering the treatment.				
Checks for right patient, right treatment, and right time.				
 Documents accurately and communicates to appropriate authority in a timely manner if patient refuses treatment, error is made, or an unpredicted event occurs. 				
Includes the individual / family / group or other health care providers and assessment data in evaluating outcomes of care and revising the plan of care.				
Documents care provided and outcomes of care in an accurate and timely manner.				
Demonstrates appropriate and effective utilization of technology, analysis of information, and selection of resources in care implementation.				
Communicates in an accurate, clear and respectful manner with patients, families, supervisors and other health care providers.				
RN Teacher Role				
Formulates a teaching plan based on a nursing assessment and patient needs with consideration given to biological, psychological, social, spiritual, cultural, developmental, environmental and economic factors.				
Includes patient, family, and health care team in formulating the teaching plan.				
Utilizes critical thinking in making decisions on the design, content, and implementation of the teaching plan with the individual / family / group.				
Provides opportunities for individual, family, or group to demonstrate and receive feedback on the learning.				
Includes individual, family, group and health care team in the evaluation of learning outcomes as well as using established learning outcome indicators.				
Modifies the teaching-plan as indicated based on feedback from the evaluation and from health care team members.				
RN Manager Role				
Coordinates, organizes, prioritizes and modifies care provided for the individual / family / group or for multiple patients.				

Clinical Competency	Satisfactory	Needs Improvement*	Not Observed*	Preceptor Initials
Demonstrates delegation or elaborates a realistic	Jansiaciory	improvement	Observeu	miliais
and safe plan based on the unit.				
Assesses the needs, the knowledge and skills of health care personnel and own ability to supervise the personnel.				
• Instructs personnel in the task to be performed and the limits of the task and seeks agreement from the delegatee that he or she will perform the task.				
 Monitors the performance of the task to ensure it was completed properly. Documents what and to whom the task was delegated and the expectations of the personnel in regard to the task and documentation. 				
Demonstrates supervision and assigning care or elaborates a realistic and safe plan based on the unit.				
 Assesses needs of the unit and personnel available. Assigns care based on scope of practice. Monitors and evaluates care provided to patients on the unit. 				
Evaluates and provides feedback to care providers responsible for providing care to patients under the RN's care.				
Uses critical thinking to problem solve and find solutions for managing care to groups of patients.				
Reviews and monitors therapy and treatment plans for effectiveness, accuracy, currency, and relevancy.				
Collaborates with interdisciplinary team members in organizing care for patients.				
Uses effective communication and conflict management skills.				
Effectively promotes teamwork among health care providers.				
RN Professional Role				
Is current in knowledge of illness care and treatment trends.				
Establishes collegial relationships with health care team and fellow RNs.				
Manages time and prioritizes activities to complete assignments.				
Is a safe practitioner that practices within his or her scope of practice as defined in the Nurse Practice Act.				
Supports and advocates for patient rights.				

APPLICANT NAME:				
Hours of Clinical Provided	Clinical hours Documented	Needs More Hours	Recommended Additional Hours	Preceptor Initials
750 hours required for Non-Licensed Practical Nurse graduates of a non-traditional program				
350 hours required for Licensed Practical Nurse applicant graduates from a RN non-traditional program				
120 hours required for applicants with license expired over 10 years with possible additional hours determined by Board				
120 hours required for applicants with license expired 6 and up to 10 years				
80 hours required for applicants with license expired 2-5 years				
*All clinical competencies must be observed. If competencies are marked "needs improvement" or "not observed," document on a separate sheet of paper the specifics of what you believe the applicant needs to be successful for each competency that is marked.				
NOTE: Instructor/Preceptor who signs this Skills Checklist and initials the "Preceptor Initials" column, must be the same Instructor/Preceptor who signed the Non-Traditional/Refresher Program Preceptor Agreement.				
I affirm that the clinical experience described on this form was conducted and completed in accordance with Colorado State Board of Nursing Rule 5.6 for Refresher Applicants and the <i>Chapter I – Rules and Regulations for the Licensure of Practical and Professional Nurses</i> for graduates of Non-Traditional Education Program Applicants. I further affirm that the clinical experience was completed under my supervision.				

I declare under penalty of perjury in the second degree that the statements made herein are true and complete to the best of my knowledge.

Printed Name and Address of Instructor/ Preceptor:	
Contact Phone Number of Instructor/Preceptor	CO License Number:
Instructor/ Preceptor Signature:	
, •	Date Signed
Student Signature:	
-	Date Signed

State Board of Nursing

Division of Professions and Occupations

Office of Licensing—Nursing

1560 Broadway, Suite 1350 Denver, CO 80202

Instructor/Preceptor should provide the original Skills Checklist in an official sealed envelope to student for submission to the