



Virginia Department of
Health Professions
Board of Nursing

9960 Mayland Drive
Suite 300
Perimeter Center
Henrico, Virginia 23233
(804) 367-4515

www.dhp.virginia.gov/nursing

**CHECKLIST INSTRUCTIONS
REINSTATEMENT APPLICATION**

Check One: RN \$225 LPN \$200

Pursuant to Virginia nursing regulation [18 VAC 90-19-190](#) a Nurse whose license has lapsed for more than one (1) renewal period shall apply for license reinstatement. **However, if your license is not active because of a suspension or revocation you must file a different (reinstatement) application.**

Note: Virginia is a compact state under the Enhanced Nurse Licensure Compact (eNLC). Under the eNLC, to receive and/or maintain an RN/LPN license with multi-state privilege(s), an applicant must meet all Uniform Licensure Requirements in accordance with [Virginia Code § 54.1-3040.3 C](#). If you do not meet all **Uniform Licensure Requirements** (ULRs) OR you reside in a 'non-compact' state, you may be eligible for a single-state license authorizing practice only in Virginia.

If your **primary state of residence (PSOR)** is a **compact** state, you must apply for licensure in your PSOR (compact state). If your primary state of residence is Virginia or a non-compact state, and your Virginia license has been **expired for more than two years**, you may apply in Virginia for reinstatement. Indicate on the application your primary state of residence. **For current information on the NLC go to:** <https://www.ncsbn.org/nurse-licensure-compact.htm>.

REQUIREMENTS BELOW - Check applicable COMPLETED items that are included with your application:

Completed Reinstatement Application and required Fee: Fees must be paid by check or money order, made payable to The *Treasurer of Virginia*. Your application will not be reviewed or considered until you have submitted payment. **Fees are non-refundable.**

Completed criminal history background check required by [Virginia Code § 54.1-3005.1](#): Within 7-10 **business** days after confirmed payment receipt for your filed application, you will receive a **Fieldprint Code**. This code is required to register for fingerprinting, which must be done exclusively through [Fieldprint Va](#). You must have a **confirmed application filed** with VBON prior to registering for fingerprinting. If you do not receive your **Fieldprint Code** within 7-10 **business** days, you may contact the [VBON CBC unit](#).

Completed continued competency requirements: Provide evidence of completing at least one (1) of the learning activities or courses specified in [18 VAC 90-19-160](#) during the two (2) years immediately preceding application for reinstatement. Applicable regulation regarding supporting documentation for compliance should be reviewed at: [18 VAC 90-19-170](#). **{30 contact hours required without active practice} OR {15 contact hours required with a minimum of 640 hours of active practice}.**

I have completed the continued competency requirements.

The Board may waive all or part of the continued competency requirement(s) for a nurse who holds a current, unrestricted license in another state AND who has engaged in active practice during the period the Virginia license was lapsed. Evidence must be provided to request that the VBON waive the continued competency requirements.

By checking this box, I am requesting VBON consider waiving continued competency requirements by providing written verification of active licensure and active practice during the time my license was expired to include:

- copy of current license (**only for non-NURSYS participating states**);
- letter from employer on official letterhead verifying: name/position/dates of employment; copy of a recent pay stub with: name/position/name of the medical facility.

Additional Information:

- The VBON may request additional evidence that the nurse is prepared to resume practice in a safe, competent manner.
- Nursing laws and regulations may be obtained at www.dhp.virginia.gov/nursing.
- Documents submitted with the application are property of the Board and cannot be returned.

THIS COMPLETED INSTRUCTION CHECKLIST MUST BE SUBMITTED WITH APPLICATION



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APPLICATION FOR REINSTATEMENT- REGISTERED OR PRACTICAL NURSE (RN or LPN)

FOR OFFICE USE ONLY (FINANCE DIVISION)

FOR OFFICE USE ONLY (VBON STAFF)

Fee paid/Check one:

RN (\$225)

LPN (\$200)

Applicant ID#:

Receipt #:

Approved:

Date:

I hereby make application to reinstate my nursing license in the Commonwealth of Virginia. The following information in support of my application is submitted with a **check or money order** made payable to the *Treasurer of Virginia* in the amount of **\$225 [RN] or \$200 [LPN]**. **The fees are non-refundable.**

Disclosure of Addresses

Pursuant to [Virginia Code § 54.1-2400.02](#) addresses of licensees are made available to the public. Normally, the Address of Record is the publicly disclosed address. If you do not want your Address of Record to be made public, you may provide a second, publicly disclosable address (e.g. work or practice address). If you would like your Address of Record to be publically available complete both sections with same address.

Disclosure of Social Security or DMV Control Numbers

Pursuant to [Virginia Code § 54.1-116 \(A\)](#), you are required to submit your social security number or your control number issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.

1. APPLICANT INFORMATION - provide the information requested below and on all pages. (Print or Type) Use full name, not initials.			Applicant Type (Check One): <input type="checkbox"/> RN <input type="checkbox"/> LPN	
Name: Last	First	Middle/Maiden	Suffix	
Address of Record (Mailing Address)	City	State	Zip	Telephone Number
Publicly Disclosable Address	City	State	Zip	Telephone Number
Email Address:				
Date of Birth: __ / __ / ____	Social Security Number or Virginia DMV Control Number*:			
Virginia RN or LPN License Number:	Full Name at Time of Initial Licensure:			
DECLARATION OF PRIMARY STATE OF RESIDENCE				
I declare that the state of: <input type="text"/> is my Primary State of Residence and that such constitutes my permanent and principal home for legal purposes. (*If not VA, refer to Compact info on the Instruction page).				

2. EMPLOYMENT INFORMATION

If employed, list your **current** Employer and job title:

Employer:

Job Title (position title):

3. UNIFORM LICENSURE REQUIREMENTS

In order to receive a license with multi-state privilege(s), an applicant must meet all [Uniform Licensure Requirements](#) in accordance with [Virginia Code § 54.1-3040.3 C](#). If you do not meet all Uniform Licensure Requirement (ULRs) OR you reside in a 'non-compact' state, you may be eligible for a single-state license authorizing practice only in Virginia. For current information on the NLC go to: <https://www.ncsbn.org/nurse-licensure-compact.htm>.

Do you meet all [Uniform Licensure Requirements](#) in accordance with [Virginia Code § 54.1-3040.3 C](#)? YES *NO

If No, provide details in **Explanation Section**.

4. LICENSURE HISTORY/QUESTIONS (pertains to any license or certificate ever issued to applicant)

- List **current** state(s) of practice:

Answer **YES** or **NO** to *EACH* of the following:

- Have you ever had disciplinary action taken against **any** license/registration/certificate to practice in a state or against your multi-state privilege to practice in a state? YES NO
- Have you ever voluntarily surrendered any license/registration/certificate or multi-state privilege issued to you to avoid disciplinary action? (Does not include allowing your license to expire or placing the license in inactive status.)
YES NO
- Have you ever had any of the following disciplinary actions taken against your license/registration/certificate or multi-state privilege by any licensing authority in any jurisdiction: placed on probation, suspended, revoked or otherwise disciplined? YES NO
- Have you ever applied for and been denied a license/registration/certificate or multi-state privilege in a health related field or jurisdiction? YES NO
- Have you ever been the subject of an investigation by any licensing authority? YES NO
- Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence and reckless driving but excluding other traffic violations)? *YES NO ***Information Previously provided**
- Within the past five (5) years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? YES NO
 - If YES, detail under **Explanation** section.
 - Within the past five (5) years, have you sought or been directed to seek treatment for your conduct or behavior?
YES NO
- Within the past five (5) years, have you been disciplined by any entity? YES NO
 - If YES, detail under **Explanation** section and provide any associated orders or letter from entity.
 - Within the past five (5) years, have you sought or been directed to seek treatment for your conduct or behavior?
YES NO
- Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing nurse.
YES NO
 - If YES, detail under **Explanation** section. (**Note:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board).

LICENSURE HISTORY/QUESTIONS CONTINUED

Answer **YES** or **NO** to *EACH* of the following:

10. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing nurse.
 YES NO
 A. If YES, detail under **Explanation** section. (**Note:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board).
11. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing nurse.
 YES NO
 A. If YES, detail under **Explanation** section. (**Note:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board).
12. Within the past five (5) years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? YES NO
 A. If YES, detail under **Explanation** section. (**Note:** The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application or have the program send this documentation directly to the Board).

4. MILITARY QUESTION(S):

13. Are you an active member or veteran of the U.S. military? YES NO
 14. Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? YES NO

EXPLANATIONS (If no information provided here: line through Section) Attach additional pages if necessary:

CERTIFICATION

I certify by entering my signature below, I am the person applying for licensure and meet the qualifications required by Virginia law and regulations. Further, I certify the information provided in this application has been personally provided and reviewed by me and that statements made on the application are *true and complete*. I understand that providing false or misleading information as well as omitting information in response to information requested in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license.

Signature:	Date:
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