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/Boards/Nursing

INSTRUCTIONS: APPLICATION- ATTESTATION/AUTHORIZATION FOR AUTONOMOUS PRACTICE - ADVANCED PRACTICE REGISTERED NURSE (APRN)

FEE: $100

Effective July 1, 2022, Virginia law and regulations allow Advanced Practice Registered Nurses (**except certified nurse midwives, certified registered nurse anesthetists and clinical nurse specialists**) with the **equivalent of 5 years of full-time clinical experience** to be able to apply for full practice authority (referred to as '*autonomous practice*'). To be eligible for authorization for autonomous practice, you must be currently licensed as an **Advanced Practice Registered Nurse** by the Virginia Boards of Nursing and Medicine and your application must be approved prior to beginning autonomous practice in the Commonwealth. To review the applicable Virginia law, see Virginia Code § 54.1-2957 and regulation 18 VAC 90-30-86.

Applicants outside of Virginia:

To be eligible to apply for authorization for autonomous practice, you must meet the requirements for licensure by endorsement as Advanced Practice Registered Nurse in Virginia in accordance with 18 VAC 90-30-85. If you are licensed as an Advanced Practice Registered Nurse or advanced practice nurse or equivalent in another state, you are required to first apply online for licensure as Advanced Practice Registered Nurse at: https://www.license.dhp.virginia.gov/apply/. Licensed Advanced Practice Registered Nurses in Virginia must have a current license as a registered nurse in Virginia or a current *multi-state privilege* license as a registered nurse in a compact state. For current compact state information go to: https://www.ncsbn.org/nurse-licensure-compact.htm.

REQUIREMENTS BELOW - Please **ensure that the applicable items** are submitted with your application to the VBON

ALL APPLICANTS MUST PROVIDE:

☐	**(1) Complete Application with required fee ($100):** Your application must include a check or money order made payable to *Treasurer of Virginia*. Your application will not be reviewed or considered until you have submitted payment and fees are non-refundable.
☐	**(2) Evidence of a current license in good standing as an Advanced Practice Registered Nurse** (out of state applicants only).
☐	**(3) Evidence of current national professional certification** issued by one of the agencies listed in 18 VAC 90-30-90 sent directly from the professional certifying organization to our office by mail or emailed to: appsupportdocs@dhp.virginia.gov. We are not able to accept a copy of the card, certificate, or email verification from the applicant.
☐	**(4) Evidence of the equivalent of five (5) years of full-time clinical experience** (at least 1,800 hours per year based on 36-hour work week) (e.g., attestation or other documentation as outlined in the attached application).

Note: A **separate** Application is required in each category in which you are licensed and certified for which you are requesting authorization for *autonomous practice* (e.g., FNP, PMHP, etc.).

ADDITIONAL INFORMATION

- ✓ **Use the 'Additional Attachment' to submit attestations from more than one (1) patient care team physician**.
- ✓ **Required** application supporting documents may be emailed to: appsupportdocs@dhp.virginia.gov.
- ✓ License application processing times are approximately 30 **business** days to complete.
- ✓ Check your **license status** on License Lookup (license information is posted in *real time*).
- ✓ Laws and regulations for Advanced Practice Registered Nurses may be accessed at: VBON Laws & Regulations.

THIS COMPLETED INSTRUCTION CHECKLIST MUST BE SUBMITTED WITH THE APPLICATION

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APPLICATION – ATTESTATION FOR LICENSED ADVANCED PRACTICE REGISTERED NURSE AUTHORIZATION FOR *AUTONOMOUS* PRACTICE

Fee:$100

FOR OFFICE USE ONLY (Completed by: FINANCE DIVISION)

VA APRN License #:	Receipt #:

In accordance with Virginia law and regulations, an Advanced Practice Registered Nurse with a current, unrestricted license, except those licensed as a **certified nurse midwife, certified registered nurse anesthetist and clinical nurse specialist**, may qualify for *autonomous practice* by completion of the equivalent of **five years of full-time clinical experience*** as an Advanced Practice Registered Nurse. *Autonomous practice* means practice in a category in which an Advanced Practice Registered Nurse is certified and licensed without a written or electronic practice agreement with a patient care team physician in accordance with 18 VAC 90-30-86. ***Five years of full-time clinical practice (post-graduate delivery of healthcare directly to patients) = 1,800 hours per year for a total of 9,000 hours (* based on a minimum 36-hour work week).**

A **separate** application for *Authorization for Autonomous Practice* is required for each category (e.g., FNP, PMHNP) for which an applicant is licensed and certified. However, if the hours of practice are applicable to the patient population and in practice areas included within each of the categories of licensure and certification, those hours may be counted towards a second or subsequent attestation.

APPLICANT INFORMATION:

Last Name:	First Name:	Middle Name:	SSN:

Mailing Address:	City:	State:	Zip:

Email:	Phone # (w/area code):
City/County in VA (Location where you intend to practice):	

APPLICANT CURRENT LICENSE INFORMATION:

I hold an ACTIVE (Check Applicable Items):

☐	Virginia RN License #:	Expiration Date:
☐	Compact Multi-State RN License #:	Expiration Date:
☐	NP, APRN or equivalent license/certification/registration #:	Expiration Date:

National Certification:	Certifying Agency:	Certification #	Expiration Date:

APRN CATEGORIES (**Check only One** Category per each application* for which you are **certified** as an APRN)

***National Certification Required for Each Application**

- ☐ 01: **Adult - Geriatric Acute Care**
- ☐ 02: **Family**
- ☐ 03: **Pediatric - Primary Care**
- ☐ 07: **Adult - Geriatric Primary Care**
- ☐ 13: **Neonatal**
- ☐ 14: **Women's Health**
- ☐ 17: **Psychiatric - Mental Health**
- ☐ 18: **Pediatric - Acute Care**

PATIENT CARE TEAM PHYSICIAN INFORMATION (*Use additional pages if more than one team physician):

Patient Care Team Physician First/Last Name:	License #:
Business Physical Address:	Contact Phone # (w/area code):

ATTESTATION COMPLETED BY EACH TEAM PHYSICIAN (If more than one team physician, attach additional pages):

By checking **both** boxes below, I **attest** to the following:

☐	I am the patient care team physician identified in this Advanced Practice Registered Nurse application. I served as a patient care team physician on a patient care team with the Advanced Practice Registered Nurse applicant pursuant to a practice agreement meeting the requirements of 18 VAC 90-30-86 and §§ 54.1-2957 and 54.1-2957.01 of the Code of Virginia; **AND**
☐	While a party to such practice agreement, I routinely practiced with a patient population and in a practice area included within the category indicated in this Advanced Practice Registered Nurse application, as specified in 18 VAC 90-30-70, for which the Advanced Practice Registered Nurse was certified and licensed during the practice period listed below for the number of hours specified.

Dates/Periods of Practice:	Hours of Practice (**1 year FT ≥ 1,800 hours**):		
	☐ 1 year	☐ 3 years	☐ 5 years or more
	☐ 2 years	☐ 4 years	☐ Other:

Signature of Patient Care Team Physician:	Date:	Printed Name of Patient Care Team Physician:

CERTIFICATION COMPLETED BY ADVANCED PRACTICE REGISTERED NURSE

CHECK ONLY ONE BOX BELOW:

☐	I certify by entering my signature below that I am the person applying for *Authorization for Autonomous Practice* as a licensed Advanced Practice Registered Nurse. I have obtained the patient care team physician attestation and I meet the requirements in accordance with 18 VAC 90-30-86, Virginia Code § 54.1-2957 and Virginia Code § 54.1-2957.01, as applicable.

-OR-

☐	I certify by entering my signature below that I am the person applying for *Authorization for Autonomous Practice* as a licensed Advanced Practice Registered Nurse. I meet the requirements in accordance with 18 VAC 90-30-86, Virginia Code § 54.1-2957 and Virginia Code § 54.1-2957.01, as applicable. However, I am unable to obtain the required attestation from a patient care team physician due his/her death, disability, retirement, relocation to another state, or other circumstance. Other circumstance may include that I was not required under the laws in the state where I am licensed/certified as an Advanced Practice Registered Nurse to enter into a practice or collaborative agreement with a patient care team physician. Therefore, I have provided **other evidence**** as part of this application for approval.

Further, I certify the information provided in this application is true and complete. If granted *Authorization for Autonomous Practice* I shall:

1. Only practice within the scope of my clinical and professional training and limits of my knowledge and experience and consistent with the applicable standards of care;
2. Consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided; and
3. Establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

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 of Licensed Advanced Practice Registered Nurse:	Date:

Additional Information:

Fee may be paid by check (business or personal) or money order payable to: *The Treasurer of Virginia.*

****Other evidence includes** official records from employment, military service, Medicaid/Medicare reimbursement or other similar records verifying full-time clinical practice in the role category as an Advanced Practice Registered Nurse.

PATIENT CARE TEAM PHYSICIAN INFORMATION (*Use additional pages if necessary):	
Patient Care Team Physician First/Last Name:	License #:
Business Physical Address:	Contact Phone # (w/area code):

ATTESTATION COMPLETED BY EACH TEAM PHYSICIAN (Use additional pages if necessary):

By checking **both** boxes below, I **attest** to the following:

☐	I am the patient care team physician identified in this Advanced Practice Registered Nurse application. I served as a patient care team physician on a patient care team with the Advanced Practice Registered Nurse applicant pursuant to a practice agreement meeting the requirements of 18 VAC 90-30-86 and §§ 54.1-2957 and 54.1-2957.01 of the Code of Virginia; **AND**
☐	While a party to such practice agreement, I routinely practiced with a patient population and in a practice area included within the category indicated in this Advanced Practice Registered Nurse application, as specified in 18 VAC 90-30-70, for which the Advanced Practice Registered Nurse was certified and licensed during the practice period listed below for the number of hours specified.

Dates/Periods of Practice:	Hours of Practice (**1 year FT ≥ 1,800 hours**):		
	☐ 1 year ☐ 2 years	☐ 3 years ☐ 4 years	☐ 5 years or more ☐ Other:

Signature of Patient Care Team Physician:	Date:	Printed Name of Patient Care Team Physician:

PATIENT CARE TEAM PHYSICIAN INFORMATION (*Use additional pages if necessary):	
Patient Care Team Physician First/Last Name:	License #:
Business Physical Address:	Contact Phone # (w/area code):

ATTESTATION COMPLETED BY EACH TEAM PHYSICIAN (Use additional pages if necessary):

By checking **both** boxes below, I **attest** to the following:

☐	I am the patient care team physician identified in this Advanced Practice Registered Nurse application. I served as a patient care team physician on a patient care team with the Advanced Practice Registered Nurse applicant pursuant to a practice agreement meeting the requirements of 18 VAC 90-30-86 and §§ 54.1-2957 and 54.1-2957.01 of the Code of Virginia; **AND**
☐	While a party to such practice agreement, I routinely practiced with a patient population and in a practice area included within the category indicated in this Advanced Practice Registered Nurse application, as specified in 18 VAC 90-30-70, for which the Advanced Practice Registered Nurse was certified and licensed during the practice period listed below for the number of hours specified.

Dates/Periods of Practice:	Hours of Practice (**1 year FT ≥ 1,800 hours**):		
	☐ 1 year ☐ 2 years	☐ 3 years ☐ 4 years	☐ 5 years or more ☐ Other:

Signature of Patient Care Team Physician:	Date:	Printed Name of Patient Care Team Physician: