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

CHECKLIST INSTRUCTIONS APPLICATION FOR RESTRICTED VOLUNTEER LICENSE

Check One:

☐ **RN $95**	☐ **Nurse Practitioner $65**
☐ **LPN $85**	☐ **RX Authority $35**

Virginia Code § 54.1-3011.01: **Restricted volunteer license for registered or practical nurses.** The Board may issue a restricted volunteer license to a registered or practical nurse who, within the past five years, held an unrestricted active license as a registered or practical nurse issued by the Board or another state, which was in good standing at the time the license expired or became inactive. A restricted volunteer license shall only be valid in the Commonwealth and shall not confer any multistate licensure privilege.

Virginia Code § 54.1-2957.001: **Restricted volunteer license for nurse practitioners.** The Board of Medicine and the Board of Nursing may jointly issue a restricted volunteer license to a nurse practitioner who (i) within the past five years held an unrestricted license as a nurse practitioner in the Commonwealth or another state that was in good standing at the time the license expired or became inactive and (ii) holds an active license or a volunteer restricted license as a registered nurse or a multistate licensure privilege. Note: A nurse practitioner holding a restricted volunteer license may obtain prescriptive authority pursuant to Virginia Code § 54.1-2957.01.

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

☐ **Completed Application and required Fee submitted to board prior to engaging in such practice**: acceptable fees include payment by 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**.

- Your signed application authorizes release of confidential information, affirms that your application is complete and correct, and attests that you have read and understand and will remain current with the laws and regulations governing the practice of nursing in Virginia. Additionally, it verifies that no remuneration will be received directly or indirectly for nursing services.

☐ For the **past five (5) years**, applicants must:

- Have held an *unrestricted* license as an RN, LPN or NP in Virginia or another state that was in good standing at the time of expiration or inactivation;
- Hold an active license, volunteer restricted license or multi-state privilege license as an RN or LPN.

☐ **Submit evidence of license verification** if you do **not** hold a Virginia license as an RN, LPN or NP.

ADDITIONAL INFORMATION

- **Check your license status by going to: License Lookup (*license information is posted in real time).**
- Nursing laws and regulations may be obtained at www.dhp.virginia.gov/Boards/Nursing.
- Documents submitted with the application are property of the Board and cannot be returned.

INSTRUCTION CHECKLIST MUST BE INCLUDED WITH APPLICATION

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APPLICATION – RESTRICTED VOLUNTEER LICENSE

FOR OFFICE USE ONLY (FINANCE DIVISION)			*FOR OFFICE USE ONLY (VBON STAFF)*	
Fee paid/Check one: ☐ RN ($95) ☐ LPN ($85) ☐ Nurse Practitioner ($65) ☐ RX Authority ($35)	**Applicant ID#:**	**Receipt #:**	**Approved:**	**Date:**

I hereby make application to for a Volunteer Restricted 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* for the applicable fee. **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** - provide the information requested below and on all pages. (Print or Type) **Use full name, not initials.**	Applicant Type (Check One): ☐ **RN** ☐ **LPN** ☐ **Nurse Practitioner** ☐ **RX Authority**			
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 :	Last 4 Digits: Social Security Number			
Virginia **RN, LPN, NP** License Number(s):	Full Name at Time of Initial Licensure:			

RECORD OF PROFESSIONAL LICENSES (Except those listed above)

State/Province:	Profession:	License #:	Issue Date:	Expiration Date:

PART 2. ANSWER THE FOLLOWING QUESTIONS. If either is answered "YES," explain in "PART E below:

1. Have you ever had disciplinary action taken against your license or certification in Virginia or any jurisdiction? YES ☐ NO ☐

2. Is there any investigation of you or action pending against you in Virginia or any other jurisdiction? YES ☐ NO ☐

3. Have you ever been convicted of a violation of local, state or federal statute, regulation or ordinance, or entered into any plea agreement relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence and reckless driving). Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed. YES ☐ NO ☐

4. 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 ☐

   A. If YES, detail under **Explanation** section.

   B. Within the past five (5) years, have you sought or been directed to seek treatment for your conduct or behavior? YES ☐ NO ☐

5. Within the past five (5) years, have you been disciplined by any entity? YES ☐ NO ☐

   A. If YES, detail under **Explanation** section and provide any associated orders or letter from entity.

   B. Within the past five (5) years, have you sought or been directed to seek treatment for your conduct or behavior? YES ☐ NO ☐

6. 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 ☐

   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).

7. 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).

8. 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).

9. 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).

APPLICATION – RESTRICTED VOLUNTEER LICENSE

PART E: 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 I 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.

I acknowledge that the restricted volunteer license sought through this application shall only be valid in compliance with the law and Board regulations for practice within the limits of my license to practice in public health or community free clinics that provide services to underserved populations pursuant to Virginia Code § 54.1-3011.01 and/or Virginia Code § 54.1-2957.001. By signing below, I also attest that I will not receive remuneration directly or indirectly for providing nursing services.

Signature:	**Date:**

Revised: 7/22/2022