COMMONWEALTH OF VIRGINIA
Department of Health Professions – Board of Nursing
Perimeter Center – 9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
(804) 367-4515 www.dhp.virginia.gov/nursing

APPLICATION FOR REGISTRATION FOR VOLUNTEER PRACTICE

☐ Registered Nurse (RN)
☐ Licensed Practical Nurse (LPN)
☐ Licensed Nurse Practitioner

INSTRUCTIONS: Use typewriter or print clearly. If the space provided for any answer is insufficient, the applicant must complete his/her answer on a separate page, signed by him/her, specifying the question to which it relates and enclose the page with this application. OMISSIONS OR INACCURACIES ARE GROUNDS FOR REJECTION. ENCLOSE A CHECK MADE PAYABLE TO THE **TREASURER OF VIRGINIA IN THE AMOUNT OF $10.**

It is not necessary to file this application if you hold a current unrestricted license or multi-state privilege to practice in Virginia.

Name (Last, First, M.I., Suffix, Maiden Name	Social Security # or DMV #

Mailing Address (Street and/or Box Number, City, State, Zip Code)

Area Code and Telephone Number	Email Address

RECORD OF ALL PROFESSIONAL LICENSURE:

State	Profession	License Number	Issue Date	Expiration Date

Has your license to practice in any state/jurisdiction been previously suspended or revoked? If **yes**, give details, jurisdiction(s) and date(s) on a separate page. No ☐ Yes ☐

Dates of Volunteer Practice	Location of Volunteer Practice

Name of Sponsoring Organization:
☐ Remote Area Medical (RAM)
☐ Other: Full name of organization: _____

ATTACH A COMPLETED CERTIFICATION FORM FROM THE SPONSORING ORGANIZATION

Have you ever been convicted of a violation or plead Nolo Contendere, to any federal, state or local statue, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor (excluding traffic violations, except convictions for driving under the influence)? If **yes**, give details, jurisdiction(s) and date(s) on a separate page, and include a copy of the disposition/record *certified* by the Clerk of the Court. No ☐ Yes ☐

I acknowledge that the licensure exemption sought through this application shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board.

SIGNATURE: _____ DATE: _____

Date Received	Fee	Pending Number	Date Registered