



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

**INSTRUCTIONS: APPLICATION- ATTESTATION/AUTHORIZATION FOR
AUTONOMOUS PRACTICE - LICENSED NURSE PRACTITIONER (LNP)**

FEE: \$100

Virginia law and regulations allow licensed Nurse Practitioners (**except certified nurse midwives and certified registered nurse anesthetists**) 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 a **nurse practitioner** 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 nurse practitioner in Virginia in accordance with [18 VAC 90-30-85](#). If you are licensed as a nurse practitioner or advanced practice nurse or equivalent in another state, you are required to first apply online for licensure as nurse practitioner at: <https://www.license.dhp.virginia.gov/apply/>. Licensed Nurse Practitioners 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 a Nurse Practitioner** (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 to include 9,000 total hours) (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 Nurse Practitioners may be accessed at: [Virginia Board of Nursing Laws & Regulations](#).

THIS COMPLETED INSTRUCTION CHECKLIST MUST BE SUBMITTED WITH THE APPLICATION



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**APPLICATION – ATTESTATION FOR LICENSED NURSE PRACTITIONER
AUTHORIZATION FOR AUTONOMOUS PRACTICE**

Fee: \$100

FOR OFFICE USE ONLY (FINANCE DIVISION)

FOR OFFICE USE ONLY (VBON STAFF)

Applicant ID #:

Receipt #:

Approved:

Date:

In accordance with Virginia law and regulations, a nurse practitioner with a current, unrestricted license, except those licensed as a **certified nurse midwife or certified registered nurse anesthetist**, may qualify for *autonomous practice* by completion of the equivalent of **five years of full-time clinical experience*** as a nurse practitioner. *Autonomous practice* means practice in a category in which a nurse practitioner 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):

<input type="checkbox"/>	Virginia RN License #:	Expiration Date:
<input type="checkbox"/>	Compact Multi-State RN License #:	Expiration Date:
<input type="checkbox"/>	NP, APRN or equivalent license/certification/registration #:	Expiration Date:

National Certification:	Certifying Agency:	Certification #	Expiration Date:
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LNP CATEGORIES (Check only One Category per each application* for which you are certified as an LNP) *National Certification Required for Each Application	<input type="checkbox"/> 01: Adult - Geriatric Acute Care	<input type="checkbox"/> 13: Neonatal
	<input type="checkbox"/> 02: Family	<input type="checkbox"/> 14: Women's Health
	<input type="checkbox"/> 03: Pediatric - Primary Care	<input type="checkbox"/> 17: Psychiatric - Mental Health
	<input type="checkbox"/> 07: Adult - Geriatric Primary Care	<input type="checkbox"/> 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:

<input type="checkbox"/>	I am the patient care team physician identified in this nurse practitioner application. I served as a patient care team physician on a patient care team with the nurse practitioner 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
<input type="checkbox"/>	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 nurse practitioner application, as specified in 18 VAC 90-30-70 , for which the nurse practitioner 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):		
	<input type="checkbox"/> 1 year	<input type="checkbox"/> 3 years	<input type="checkbox"/> 5 years or more
	<input type="checkbox"/> 2 years	<input type="checkbox"/> 4 years	<input type="checkbox"/> Other:

Signature of Patient Care Team Physician:	Date:	Printed Name of Patient Care Team Physician:
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CERTIFICATION COMPLETED BY NURSE PRACTITIONER**CHECK ONLY ONE BOX BELOW:**

<input type="checkbox"/>	I certify by entering my signature below that I am the person applying for <i>Authorization for Autonomous Practice</i> as a licensed nurse practitioner. 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.
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-OR-

<input type="checkbox"/>	I certify by entering my signature below that I am the person applying for <i>Authorization for Autonomous Practice</i> as a licensed nurse practitioner. 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 <u>unable</u> 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 a nurse practitioner 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.
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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 Nurse Practitioner:	Date:
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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 a licensed/certified nurse practitioner.

LNP Attestation Application **ADDITIONAL ATTACHMENT: FOR MORE THAN ONE (1) 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:		
<input type="checkbox"/>	I am the patient care team physician identified in this nurse practitioner application. I served as a patient care team physician on a patient care team with the nurse practitioner 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	
<input type="checkbox"/>	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 nurse practitioner application, as specified in 18 VAC 90-30-70 , for which the nurse practitioner 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):
		<input type="checkbox"/> 1 year <input type="checkbox"/> 3 years <input type="checkbox"/> 5 years or more <input type="checkbox"/> 2 years <input type="checkbox"/> 4 years <input type="checkbox"/> 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:		
<input type="checkbox"/>	I am the patient care team physician identified in this nurse practitioner application. I served as a patient care team physician on a patient care team with the nurse practitioner 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	
<input type="checkbox"/>	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 nurse practitioner application, as specified in 18 VAC 90-30-70 , for which the nurse practitioner 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):
		<input type="checkbox"/> 1 year <input type="checkbox"/> 3 years <input type="checkbox"/> 5 years or more <input type="checkbox"/> 2 years <input type="checkbox"/> 4 years <input type="checkbox"/> Other:
Signature of Patient Care Team Physician:	Date:	Printed Name of Patient Care Team Physician: