



# Oregon Application for LPN/RN/APRN Licensure by Renewal

**NOTE:** This application is also available to renew online by going to the OSBN website at [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN).

## Section 1: Application Instructions

- Complete this application if you are renewing an active license/certificate OR if it has been less than 61 days from the expiration date. **If it is more than 60 days past due, you must use the application form LIC-105 Oregon Application for LPN/RN/APRN Licensure by Reactivation.** It is available on the OSBN website at [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN) in the Forms section.
- If you are using your active national certification to meet CE requirements, include a copy that lists your identification number and expiration date to update your OSBN records.
- If you do not have the required amount of practice hours based on your type of license/certificate, you must first complete an OSBN-approved nurse re-entry program before your full licensure is reactivated. Contact OSBN at 971-673-0685 for more information regarding the separate application requirements.
- Submit the original application to OSBN via postal mail- copies are not accepted. **If your legal name has changed since your last renewal or expiration, you must submit proof.** See OSBN-601 [Name Change and/or Address Change Request Form](#).
- Mail application materials and form of payment to: OSBN 17938 SW Upper Boones Ferry Rd, Portland OR 97224.
- **Allow a minimum of 10 business days to review application requirements.**

## Section 2: Application Fee Table- All application fees are non-refundable.

- Timely Receipt of Application:** Applications received at the OSBN office by the close of business (or submitted online by midnight) on the date of expiration of their license/certificate are deemed received in a timely manner.
- Late Fee Accruals:** All application(s) received after the above timeframe will incur a \$100 late fee automatically applied to each applicable license per OAR 851-002-0000.

License Type	Timely Renewal (a)	Late Renewal (b)
LPN or RN	\$158	\$258
RN with CRNA	\$213	\$413
RN with CRNA-PP	\$313	\$513
RN with CNS	\$233	\$433
RN with CNS-PP	\$313	\$513
RN with NP-PP (one NP-PP)	\$313	\$513
If renewing more than one NP-PP type:	Add <b>\$50</b> for EACH additional specialty.	Add <b>\$150</b> for EACH additional specialty.
<small>Surcharges: All LPN/RN application fees include a \$4 biennial surcharge per application for the operation and maintenance of the Oregon Healthcare Workforce Database. LPN/RN renewals include a \$9 surcharge to fund the Oregon Nursing Advancement Fund that is remitted to the Oregon Center for Nursing (OCN) to fund work to advance the profession of nursing.</small>		

## Section 3: Pain Management Continuing Education

All Oregon health care providers are mandated to complete a **one-time** requirement of seven hours of pain management-related continuing education (CE) within 24 months from the first license renewal. The Oregon Pain Management Commission offers a one hour training on their [website](#) that must be completed as one hour towards the total required.

Notice to Applicants with Disabilities: If you have a disability and require special materials or assistance to complete this application, please contact OSBN at 971-673-0685. If you are hearing impaired, you may contact OSBN through the Oregon Relay Service at 1-800-735-2900.



**Oregon State Board of Nursing**  
 17938 SW Upper Boones Ferry Rd.  
 Portland, OR 97224-7012  
 971-673-0685  
 www.oregon.gov/OSBN

# Oregon Application for LPN/RN/APRN Licensure by Renewal

**NOTE:** Please read the attached information page before completing this application. Use only blue or black ink and print all information legibly. Faxed or emailed applications are not accepted.

## Section 1: Status of Oregon License/Certification

<input type="checkbox"/> <b>Timely Renewal:</b> My license/certification is <b>Active</b> .	I am renewing my: <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> APRN: type _____
<input type="checkbox"/> <b>Late Renewal:</b> Expired less than 60 days.	License Number(s):

## Section 2: Applicant Information

Last Name:		First Name:	
Middle Name:		Former Name(s) Used:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (mm/dd/yyyy):                    /                    /		
Address:			
City:		State:	Zip:
Country:		Email:	
Primary Telephone: <input type="checkbox"/> Unlisted		Secondary Telephone: <input type="checkbox"/> Unlisted	
I prefer to be contacted by: <input type="checkbox"/> telephone <input type="checkbox"/> email <input type="checkbox"/> postal mail			

## Section 3: Work History- Start with your most recent. If you have not practiced in the five years from the date of application, list the last position you held prior to leaving practice.

Date that you last practiced nursing (mm/dd/yyyy): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I have completed the mandatory one-time requirement of seven hours of pain management.

Company Name:		Telephone:	
Address:		City:	State:      Zip:
Position Title:		License Number Used:	Licensing State:
Still Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date (mm/dd/yyyy):		End Date (mm/dd/yyyy):
Paid Practice: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of practice hours in this position in last five years (required):			

Company Name:		Telephone:	
Address:		City:	State:      Zip:
Position Title:		License Number Used:	Licensing State:
Still Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date (mm/dd/yyyy):		End Date (mm/dd/yyyy):
Paid Practice: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of practice hours in this position in last five years (required):			

OSBN USE ONLY-Applicant Name (last name, first name)

OSBN USE ONLY- License Number & Expiration Date

OSBN USE ONLY- Additional Information

NURSYS/FITS    App Expiration Date: \_\_\_\_\_  
 National Cert /CEs: \_\_\_\_\_

**NOTE: This page is for your information only. Please remove this page from your completed application before submitting to OSBN.**

**Section 4a: Instructions for Disclosure Section**

The following instructions provide you with specific information for what is required to continue processing your application. You are responsible for contacting the appropriate agencies to obtain the required documents to submit with your application. **Please read the following instructions carefully. Your application will not be considered complete until all documents are received.**

**Question 1(a) & (b) & (c): Use of Alcohol or Drugs**

If you answered YES to one or more of these questions, provide a detailed written explanation. Describe your alcohol/drug use history and details of any treatment with relevant dates. Provide any available documentation of your sobriety (e.g. letters, program records, or certificates of completion), if applicable.

You may answer NO if: You are currently enrolled in Oregon's Health Professionals Services Program (HPSP) as a **Self-Referral**. "*Self-referral*" means that you have independently and voluntarily enrolled in HPSP, and are being monitored. If you have had a Board investigation that resulted in your enrollment, **you must answer YES**.

**Question 2: Ability to Practice Nursing Safely**

If you answered YES, provide a detailed written explanation of your condition, its effects, and how you manage your condition.

**Question 3: Criminal History**

If you answered YES, provide a detailed written explanation. Describe the incidents that led to each arrest/charge, and the surrounding circumstances. Include relevant dates, the city and state where the incidents occurred, and the outcome of any criminal charges. Provide a copy of the court judgment and sentencing order or court order of dismissal, and documents providing evidence that you have completed or are in compliance with any court-ordered activities.

**Question 4: Investigations for Abuse or Mistreatment**

If you answered YES, provide a detailed written explanation. Provide the name of the agency that conducted the investigation. Provide documentation of the outcome of the investigation and any investigative reports.

**Question 5(a) & (b): Investigations for Healthcare Violations**

- a) If you answered YES, provide a detailed written explanation. Describe the alleged violation with relevant dates. Provide the name of the agency that conducted the investigation. Provide documentation of the outcome of the investigation and any investigative reports.
- b) If you answered YES, provide a detailed written explanation. Indicate the law or rule that was found to be violated with relevant dates. Provide documentation of the final determination.

**Question 6(a) & (b): Discipline for Healthcare Violations**

If you answered YES, provide a detailed written explanation. Describe the incidents that led to the discipline and the surrounding circumstances with relevant dates. Provide documentation of the final determination.

**Question 7: Credentialing Privileges**

If you answered YES, provide a detailed written explanation. Describe the incidents that led to the action against your privileges, and the surrounding circumstances with relevant dates. Provide documentation of the final determination.

**Question 8: Malpractice**

If you answered YES, provide a detailed written explanation. Describe the incidents that led to the action for notice or civil judgement against you. Provide documentation of the final determination.

## Section 4b: Disclosure

Before answering the questions below, please review the disclosure instructions for information to provide regarding any disclosure(s). Providing false, misleading, or incomplete information is considered falsifying an application and is grounds for denial of your application or discipline on your license/certification.

I understand I must provide the Oregon State Board of Nursing (OSBN) with any updates to information required in this application while it is pending.

1	a) Since the date of your last renewal, have you used alcohol or any drugs in a way that could impair your ability to practice nursing or perform nursing assistant duties with reasonable skill and safety?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
	b) Since the date of your last renewal, have you been diagnosed with or treated for an alcohol or any drug-related conditions?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
	c) Since the date of your last renewal, have you used any illegal drugs, or prescription drugs in a manner other than prescribed?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
<p><b>ATTENTION:</b> You must answer <b>YES</b> if you are enrolled in an impaired nurse program in any state or jurisdiction <b>including Oregon</b>. <b>If you are a self-referral to the Oregon Health Professionals Services Program (HPSP)</b>, please review the disclosure instructions for Question 1 that include the definition of "self-referral", before answering any of these questions.</p>			
2	Other than any information you may have provided in Question 1, since the date of your last renewal, do you have a physical, mental or emotional condition that could impair your ability to practice nursing or perform nursing assistant duties with reasonable skill and safety?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
3	Other than a traffic ticket, since the date of your last renewal, have you been arrested, cited, or charged with an offense? <b>ATTENTION:</b> This includes outstanding restraining orders, all arrests, citations, or charges for felony or misdemeanor crimes, <b>even if you were not convicted of any charge</b> (for example- no charges were filed, case was dismissed, or you entered a diversion program). <b>Driving under the influence must be reported here.</b>	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
4	Since the date of your last renewal, have you been part of an investigation for any type of abuse or mistreatment, in any state or jurisdiction? Include any pending investigations. <b>ATTENTION:</b> You must answer <b>YES</b> to this question even if the allegation was not substantiated.	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
5	a) Since the date of your last renewal, have you been investigated for any alleged violation of any state or federal law, rule, or practice standard regulating a health care profession? Include any pending investigations.	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
	b) Since the date of your last renewal, have you been found in violation of any state or federal law, rule, or practice standard regulating a health care profession? <b>ATTENTION:</b> Question 5a) and 5b) include disclosure of any civil, criminal, administrative, licensing, or credentialing proceedings.	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
6	a) Since the date of your last renewal, has an agency taken action against any healthcare license or certificate you have held in any other state or jurisdiction? <b>ATTENTION:</b> Question 6a) includes the disclosure of a denial, revocation, suspension, restriction, reprimand, censure, probation, loss of privileges, or any other formal or informal action.	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
	b) Since the date of your last renewal, have you withdrawn an application, or surrendered a license or certificate to avoid any of the actions listed above?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
7	Since the date of your last renewal, have you had privileges to practice in a credentialed facility or participation in a federally qualified insurance program (e.g. Medicare or Medicaid) denied, restricted, suspended, revoked, or terminated for cause?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
8	Since the date of your last renewal, have you had a notice filed or a civil judgement awarded against you for malpractice, negligence, or incompetence relating to your ability to practice as a health care professional?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO

Applicant Last Name

First Name

**SKIP SECTION 5 AND CONTINUE BELOW TO SECTION 6 IF YOU ARE NOT AN OREGON APRN.**

**Section 5a: APRN Prescribing and Dispensing**

**1. Prescriptive Authority**

- I have read the [Prescriptive and Dispensing Authority in Oregon for Advanced Practice Registered Nurses](#) handbook, and have maintained compliance with regulations for APRN nurses who prescribe and dispense prescription drugs in Oregon; **AND**
- I attest to completion of at least 150 practice hours utilizing current prescriptive authority within the scope identified in OAR 851-056-0004(1-2), within two years from the date of this application; **OR**
- I do not meet the practice hour requirement for renewal. I have completed an OSBN-approved 45-hour pharmacology course within the past two years to satisfy the requirement. **NOTE: Include a copy of the certificate of completion.**

**2. Dispensing Authority**

I have an active dispensing license in Oregon by meeting requirements set forth in OAR 851-056-0020.

- NOT APPLICABLE- I do not have a dispensing license in Oregon, only the authority to prescribe.
- YES- however I am not renewing my current dispensing authority and understand it will lapse on the expiration date.
- YES- I have a current dispensing license and want to renew it.

**3. Federal DEA Registration**

- I have a valid federal DEA number
- I do not currently prescribe controlled substances in Oregon and therefore do not have a DEA number at this time.

**Section 5b: APRN National Certification and CE Requirements**

Complete **only the section that corresponds to your license type**. All attestations made below to meet licensure requirements are subject to random audit for proof of validity.

<b>APRN with Prescriptive Authority (NP-PP/CNS-PP/CRNA-PP)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1. I meet the CE requirement by maintaining active unencumbered national certification for the type of APRN licensure I hold in Oregon. <b>IF NO- see #2.</b>		
2. I have completed at least 45 structured contact hours of CE's in the two years from the date of application, with 15 of those hours being in APRN-level pharmacotherapeutic content.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>CNS without Prescriptive Authority</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1. I have completed 40 contact hours of CE's in the two years from the date of this application. <b>ATTENTION:</b> CE's must be at least 50% structured accredited content. Proof of valid CNS national certification may be used for up to 50% structured of the total hours required.		
2. If <b>NO</b> , have you graduated from your CNS program within two years from the date of application? Graduation date (mm/dd/yyyy) : _____ Total Prorated CE Hours Completed: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>CRNA without Prescriptive Authority</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1. I have current unencumbered national certification from the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).		

**Section 6: Authorization**

I understand I have a duty to provide the Oregon State Board of Nursing with any updates to information required in this application while it is pending. I hereby certify that I have read this application, and that the information provided is true and correct. I have personally completed this application. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or discipline of license/certification. I am aware that the Oregon State Board of Nursing will conduct criminal records checks through the Oregon Law Enforcement Data System (LEDS) and the Federal Bureau of Investigation (FBI).

I do not want my name and address shared with non-state agencies or for non-public health planning purposes. I understand this does not apply to requests made to OSBN for public information as authorized by ORS 192.420.

Applicant Signature	Date (mm/dd/yyyy):
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