



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

# Oregon APRN Application For Initial Clinical Nurse Specialist Certification

Before submitting an application and fees for Advanced Practice Registered Nurse (APRN)- Initial Clinical Nurse Specialist licensure, please review the Oregon Nurse Practice Act, Division 54: *Clinical Nurse Specialists*, and if applying for prescriptive authority, Division 56: *Advanced Practice Registered Nurse Authority to Prescribe and Dispense*, available on the OSBN website at [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN).

## Section 1: Application Instructions

- Allow approximately 3 weeks from the date the application and full payment are received by OSBN to review all application requirements. A Clinical Nurse Specialist (CNS) application for licensure is valid for one year from the received paid date and will become null and void upon expiration.
- A national fingerprint-based criminal background check conducted by OSBN is required to apply for and obtain licensure/certification in Oregon. Applicants will be charged a separate fee of \$64.50 by Fieldprint Inc., an independent organization contracted by the State of Oregon to provide electronic fingerprinting services. **This fee is payable only to Fieldprint Inc. while registering on their website to schedule an electronic fingerprinting appointment.**
- **If you are simultaneously applying for Oregon RN licensure by Endorsement or Reactivation, OR were issued a different type of OSBN license/certificate within six (6) months from the date of this application**, you do not need to complete a separate fingerprint-based background check for this application. Criminal background checks completed by employers, other agencies, or other state and US jurisdictions cannot be used for OSBN licensure/certification purposes.
- Once your application and full payment are received, we will send you instructions via email or postal mail (if you do not provide an email address) on how to register with Fieldprint Inc. to schedule and pay for your fingerprinting appointment.

**Section 2: Application Fee Table-** Please see below for all fees required in order to process your application(s).

Application Type	Fee
APRN Initial CNS Certification Application (form LIC-206)	<b>\$150</b>
APRN Prescriptive Authority (form LIC-204)- Optional for CNS	<b>\$75</b>

## Section 3: Application Checklist

Please review the following checklist items to ensure that you are submitting a completed application for processing.

- Complete all sections and sign and date the application. Submit original applications to OSBN- copies are not accepted.
- Submit payment by check or money order made payable to the Oregon State Board of Nursing with your application materials. Failure to submit the correct amount may delay processing. **All application fees are non-refundable.**
- Contact your school to request official sealed final transcripts that indicate the degree/diploma/certificate awarded and the graduation date of your qualifying CNS program, be sent directly to OSBN in a sealed school envelope. Or if your school subscribes to a national document transfer network, you may request the service to send official electronic transcripts to OSBN at: [osbn.transcripts@state.or.us](mailto:osbn.transcripts@state.or.us)
- If you want to have your active unencumbered CNS national certification on file with OSBN, you may send a copy lists your identification number and expiration date. It will be displayed on your online verification report upon issuance of CNS certification.

For questions regarding the application process, please call OSBN at 971-673-0685, or you may send an email message to the general OSBN address at: [oregon.bn.info@state.or.us](mailto:oregon.bn.info@state.or.us)

Mail all application materials and form of payment to:

**Oregon State Board of Nursing**  
**17938 SW Upper Boones Ferry Rd**  
**Portland OR 97224**

**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.



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# Oregon APRN Application Information For Initial Clinical Nurse Specialist Certification

## **Section 4: Education Requirement**

Per OAR 851-054-0040, all applicants for CNS licensure in Oregon must show proof of qualifying education that made them eligible for licensure. **All applicants for CNS licensure must hold a graduate degree in Nursing, or a Post-Master's Certificate with evidence of CNS theory and clinical concentration from an accredited graduate-level nursing program recognized by the US Department of Education.** The qualifying CNS program must be one year or more in length. Graduates after January 1, 2007 must have at least 500 hours of clinical practicum completed within their program.

**NOTE: If you are applying for a CNS license with prescriptive authority,** your program must include graduate level stand-alone nursing courses in physical assessment, pathophysiology, and pharmacological content, as verified upon receipt of your official transcript. Per OAR 851-056-0006(6) integrated courses in pathophysiology and physical assessment completed prior to January 1, 1996 may be acceptable if content otherwise is equivalent.

## **Proof of Completion of Qualifying APRN CNS Nursing Program**

Official sealed final transcripts that indicate the degree/diploma/certificate awarded and the graduation date from the qualifying APRN nursing program are required to process your application. OSBN accepts sealed official transcripts via postal mail, or electronic transcripts sent directly from the national document transfer network that your school subscribes to.

## **Section 5: Practice Requirement**

### a. CNS Practice Requirement:

1. Completion of the qualifying CNS program within the two years prior to application; **OR**
2. Practice as a CNS for at least 192 hours within the past two years from date of application; **OR**
3. 960 hours of CNS practice within the last five years from the date of application.

### b. APRN Prescriptive Authority Practice Requirement:

1. Graduation from an accredited CNS education program within two years prior to application (practice requirement is waived); **OR**
2. Current, unencumbered prescriptive authority in another state, US jurisdiction, or federal facility/institution; AND completion of a minimum of 150 hours in the two years prior to application utilizing that authority; **OR**
3. Validation of prescribing competencies in current practice by a licensed independent prescribing practitioner that demonstrates 150 hours of clinical expertise in differential diagnosis and applied pharmacological management.

## **Section 6: National Certification**

Applicants for Oregon CNS certification may choose to submit a copy of their valid unencumbered national certification from an accrediting national body. If you would like your national certification to be on file with OSBN, submit with your application a copy that lists your identification number and expiration date. It will subsequently be displayed on the OSBN online verification system with your licensure details upon issuance of CNS certification.



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**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 will not be accepted; an original application with signature is required.

## Section 1: Name and Address Information

Last Name:		First Name:	
Middle Name:		Former Name(s) Used:	
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 2: Personal Identifiers

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (mm/dd/yyyy):        /        /
Social Security Number (SSN):	
NOTE: Your SSN is required by the state for child support enforcement, tax administration purposes (including identification), and criminal background checks ONLY. Refusal to provide your SSN may result in denial of issue of a license/certificate and your SSN would be reported to the federal Health Care Integrity and Protection Data Bank, as authorized by ORS 305.385 USC Section 666(a)(13).	

## Section 3: CNS Education Program

List the program you completed that qualifies you for CNS certification. Resumes or individual coursework are not accepted in lieu of completing this section.

Name of School		
City	State/Jurisdiction	Country
Degree/Certificate Earned		
<input type="checkbox"/> Nursing Diploma	<input type="checkbox"/> Bachelor's Degree in Nursing	<input type="checkbox"/> Post-Masters Certificate
<input type="checkbox"/> Associate's Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing	<input type="checkbox"/> Doctorate Degree in Nursing
	<input type="checkbox"/> Master's Degree in Nurse Anesthesia	<input type="checkbox"/> Other: specify
Date Enrolled (mm/dd/yyyy)	Date of Graduation (mm/dd/yyyy)	
Name on Transcript		

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

OSBN USE ONLY - License Number & Expiration Date

OSBN USE ONLY - Policy Analyst Review  
Staff Signature: \_\_\_\_\_  
Approval Date: \_\_\_\_\_

**NOTE: This page is for your information only. Please remove 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 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) In the last five years, 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) In the last five years, 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) In the last five years, have you used any illegal drugs, or prescription drugs in a manner other than prescribed?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
<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.			
2	Other than any information you may have provided in Question 1, 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, have you ever 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	Have you ever 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) Have you ever 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) Have you ever 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) Has an agency ever 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) Have you ever 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	Have you ever 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	Have you ever 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:

## Section 5: CNS Practice History

List your practice history starting with the **most recent** employer, through the last five years from the date of your application.

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

## 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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