State of New Hampshire
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF HEALTH PROFESSIONS
Board of Nursing
7 Eagle Square Concord NH 03301
Telephone 603-271-2323 · Fax 603-271-2856

Name
Address
Town/City

License #
Date of Birth:

Application for License Reinstatement: Advanced Practice Registered Nurse (A.P.R.N.)

- If you are submitting by mail - please print legibly, sign and submit this checklist along with your paper reinstatement application.
- All documents must be received in the Board office before your license can be reinstated.
- The reinstatement process cannot be completed until your application (completely and accurately filled out) and appropriate fees have been received and reviewed.
- The Verification link on the New Hampshire Board of Nursing website will be updated as soon as your license has been reinstated. Please feel free to check your license status at https://nhlicenses.nh.gov/Verification/ at any time.
- Application / licensing process not completed within 120 days will be purged.
- New Hampshire has a mandatory licensing law. No one shall practice nursing in New Hampshire without a current New Hampshire license or a current license in a compact state.
- Sources used to determine a nurse's primary residence for the Nurse Compact include but are not limited to: driver's license, federal income tax return, and voter registration.

1. _____ Yes, I hold a current registered nurse license in New Hampshire or in another compact state.
2. _____ Yes, I have completed and attached the APRN Application for License Reinstatement.
   You must answer ALL questions, and sign and date pages 2 and 3 of this form. Failure to do so will result in the application being returned to you and a delay in license reinstatement.
3. _____ Yes, I have included documentation of successful completion of 30 educational contact hours, 5 of which must be in the area of pharmacology, earned within the 2 years immediately prior to the application date.
4. _____ Yes, I have included a copy of my current certification from a national certifying association in my practice category, which counts for 30 of the 60 educational hours.

5. _____ Yes, I have used advanced nursing knowledge, judgment and skills for a minimum of 400 hours of active in practice in the requested APRN category within the 4 years immediately prior to the date of application.

6. _____ Yes, I have attached a **check or money order for $100.00 made payable to "Treasurer, State of New Hampshire"**. *Fees are not refundable.*

    a. **Fines:** For practicing without a current license – an additional $50.00 for the first month (or part thereof); and $50.00 every 30 days thereafter (or part thereof).

7. Select the appropriate box below:

    a. _____ Yes*, I have an active NH DEA # and I have registered with the NH Prescription Drug Management Program.
        i. NH DEA # _____
        ii. _____ * If the answer to question 7.a. is "Yes", I have submitted evidence of 3 of the 5 contact hours required in either opioid prescribing, pain management or substance abuse disorder.

    OR

    b. _____ Not applicable

_____	_____	_____
Print Name	Signature	Date

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1. Current RN License Number and State of Licensure: _____
2. Expiration Date (if licensed in another Compact State): _____
3. Current Employer: _____
4. Address of current employer: _____
5. Phone number: _____ Date current employment began: _____
6. Have you ever received disciplinary action against any nursing assistant license, certification or nursing license, in any state or jurisdiction including reprimand, probation, suspension, revocation, educational or practice stipulations, fines or voluntary surrender?
   _____ Yes _____ No
7. Are you currently participating in a substance abuse and/or alcohol or drug treatment program or have been diagnosed with a substance abuse disorder which in any way currently affects or limits your ability to practice safely and in a competent and professional manner??
   _____ Yes _____ No
8. Have you ever been convicted of a felony **or any criminal act**, not including traffic offenses?
   (Note: Driving While Intoxicated and Driving Under the Influence are not "traffic violations".)
   _____ Yes _____ No
9. Do you have a mental or physical problem that makes you incompetent to provide nursing-related activities?
   _____ Yes _____ No
   If you answered "Yes" to any question 7 through 10, you must attach a letter of explanation.
10. Have you worked in New Hampshire as an APRN since your license expired?
    _____ Yes - list dates worked: _____ _____ No
11. Do you want your name and address on a list of nurses that may be made available for purchase?
    _____ Yes _____ No

UNDER PENALTY OF LAW, I state the information provided is accurate to the best of my knowledge and belief. I understand knowingly providing false information may be grounds for denial, probation, reprimand, suspension or revocation of a license (RSA 326-B:37) and may be grounds for conviction of a misdemeanor (RSA 641:3).

_____ _____ - _____ - _____ _____
Full signature **Social Security # (required)** **Date of application**

_____ _____ _____
If applicable – change of mailing or legal address (if different from mailing address) or name **Phone** **Email address**