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 License #

Address

Address

Application for License Reinstatement: Nursing Assistant

- 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.

1. _____ Yes, I have completed and attached the NH Board of Nursing / Nursing Assistant Application for License Reinstatement.

   You must answer ALL questions, and sign and date page 3 of this form. Failure to do so will result in the application being returned to you and a delay in license reinstatement.

2. _____ Yes, I have attached a check or money order for the correct reinstatement fee of **$35.00 payable to "Treasurer, State of New Hampshire"** (fees are non-refundable).
   a. **Fines**: **$50.00 for each month** (or part thereof) for practicing without a current NH LNA license.

3. _____ Yes, I have attached a copy of my test results if currently tested. **(Test results must be sent with application or the application will be returned.)**

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Application for License Reinstatement: Nursing Assistant

1. Current Employer: _____
2. Address of current employer: _____
3. Phone number: _____ Last date worked as a LNA: _____
4. Select the appropriate box below:

   _____ I have provided a minimum of 200 hours of nursing related activities under the supervision of a licensed nurse within the 2 years immediately prior to this application.

   OR

   _____ I have successfully completed Written and Clinical Competency Testing within the 2 years immediately prior to this application.

5. Select the appropriate box below:

   _____ I have completed 24 contact hours of continuing education within 2 years immediately prior to this application.

   OR

   _____ I have successfully completed Written and Clinical Competency Testing within the 2 years immediately prior to this application.

6. Name and phone number of Facility where I provided nursing-related activities under the supervision of a licensed nurse:
   a. Name: _____
   b. Phone number: _____
7. First and Last Name of the Licensed Nurse who provided supervision: _____
8. 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

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9. Have you ever been impaired by or diverted any chemical substances that impaired your ability to practice nursing?

   _____ Yes* _____ No

10. 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

11. 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 9 through 12, you must attach a letter of explanation.

12. Have you worked in New Hampshire as an LNA since your license expired?

    _____ Yes - list dates worked: _____ _____ No

13. Do you want your name and address on a list of nurses that may be made available for purchase?

    _____ Yes _____ No

14. Do you want your name and address on a list that may be made available for individuals conducting health care research?

    _____ 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**

_____ _____ _____

Date of birth **E-mail address** **Phone**

_____

Change of mailing address or name (if applicable)