

Georgia Board of Nursing – Application for Reinstatement of Authorization as an Advanced Practice Registered Nurse

Please follow these easy steps to ensure that your application is processed as quickly as possible.

**This application should be completed by individuals who are reinstating their APRN Authorization in Georgia and have:
An Active RN (Registered Nurse) license in Georgia or
An Active Multistate RN license in another Nurse Licensure Compact State/Jurisdiction other than Georgia**

1. Complete the application in its entirety. Indicate N/A for any blanks that are not applicable.
2. Board rules chapter 410-11 require applicants for reinstatement of authorization to be certified by one of the national certifying bodies recognized in Board Rule 410-11-.12. Please request your national certifying body to submit verification of national certification to the Georgia Board of Nursing at nursing@sos.ga.gov.
3. You must hold an active RN license in Georgia or an active multistate RN license in another Nurse Licensure Compact state/jurisdiction to be eligible for authorization as an advanced practice registered nurse in Georgia. If you hold an RN license in any compact state other than Georgia, request verification of RN licensure be made available to the Georgia Board of Nursing by visiting www.nursys.com. Paper verifications are only accepted from jurisdictions that do not provide verifications through Nursys.com.
4. Board rules chapter 410-11 require applicants for reinstatement of authorization to document one of the following:
 - 1) Graduation from an advanced practice nursing education program within four years of the date of application.
 - 2) Five hundred (500) hours of practice as an advanced practice registered nurse (based on the definition of “Advanced Nursing Practice” found in O.C.G.A. §43-26-3) within the four years preceding the date of this application; or,
 - 3) Completion of a Board approved advanced practice reentry program as described in Board Rule 410-4-.04. Have your employer complete the attached “Verification of Employment Form” or submit a copy of your transcripts documenting graduation from an accredited APRN education program to provide documentation of active practice within the four years preceding the date of this application.
5. The Board requires applicants to disclose all previous arrests, history of treatment for substance abuse or dependence, and discipline by other regulatory boards. If you have ever been arrested, received treatment, or been disciplined by any other regulatory board or agency please provide a certified copy of the official documents showing the final disposition or order relevant to the incident as well as a personal, detailed letter of explanation regarding each incident. If you are required to submit treatment information, please include all information relevant to your diagnosis, prognosis, treatment plan, practice recommendations, and discharge summary.
6. Georgia law requires applicants to submit secure and verifiable documentation regarding their United States citizenship status. Submit a copy of your driver’s license, United States passport or other document as indicated on page 3 of the application packet. To avoid processing delays please submit the required documentation as part of your application packet.
7. Have your completed and signed application notarized.
8. Include a check or money order payable to the Georgia Board of Nursing in the amount of \$90 application fee + \$10 processing fee = \$100. Please note that application fees are non-refundable.
9. Mail your completed application to the Georgia Board of Nursing for processing. Applications are processed in the order in which they are received. **To avoid processing delays, please be sure to include all required documentation with your application packet.** Applications are valid for sixty (60) days from the date of submission. When mailing your application please use a 9x12 envelope and do not fold or staple any of the documents.

You must not engage in practice as an advanced practice registered nurse in Georgia until you are authorized by the Georgia Board of Nursing.

Georgia Board of Nursing - Information for APRNs Seeking Prescriptive Authority

If you plan to seek prescriptive authority in Georgia under O.C.G.A. S 43-34-25 you must first have a nurse protocol agreement approved by the Georgia Composite Medical Board. Please use the following guide to complete the process:

1. Submit your application for authorization as an APRN to the Georgia Board of Nursing.
2. After you have been authorized as an APRN by the Georgia Board of Nursing please visit the Georgia Composite Medical Board's website at <https://medicalboard.georgia.gov/> click on "Professional Resources," select "Applications Center" and select the link for "Nurse Protocol (APRN) Agreement." Follow the online instructions to submit your application for approval.
3. After your nurse protocol agreement has been approved by the Georgia Composite Medical Board please contact the Drug Enforcement Agency (DEA) at <https://deaddiversion.usdoj.gov/> for information on submitting your application for a DEA number.

Please note, you must be authorized as an APRN by the Georgia Board of Nursing and have a nurse protocol agreement approved by the Georgia Composite Medical Board prior to seeking a DEA number.

4. Georgia law requires all prescribers to register with the Georgia Prescription Drug Monitoring Program. Please visit <https://dph.georgia.gov/pdmp> for information regarding the registration process.



Georgia Board of Nursing

237 Coliseum Drive
Macon, Georgia 31217
(404) 424-9966

<https://sos.ga.gov/georgia-board-nursing>

Application for Authorization as an Advanced Practice Registered Nurse by Reinstatement

\$90 Application Fee + \$10 Processing Fee = \$100
(Processing Fees Are Nonrefundable)

Date Entered _____
Receipt # _____
Submitted \$ _____
Certificate # _____
Date Issued _____

Select the scenario that applies to you (only check one box): See O.C.G.A. 43-26-7.1(b)(1)(B)

- ☐ I hold an Active RN License in Georgia.
☐ I hold an Active Multistate RN License in Another Compact State/Jurisdiction.

☐ Please check this box if you are a military spouse or a transitioning service member of the United States armed forces (including the National Guard).

Demographic Information

Please Print Legibly or Type all Information

Last Name:	First Name:
Middle Name:	Previous Name(s):
Social Security Number:	Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email:

Physical Address Information – Applicants must provide a physical address of record.
A post office box is not acceptable for this field.

Physical Address:

City:	State:	Zip:
-------	--------	------

Mailing Address Information - Pursuant to O.C.G.A. §43-1-2(k), if issued a license, your mailing address and license number are public information and will appear on the Board's. A post office box may be used for this field.

Mailing Address:

City:	State:	Zip:
-------	--------	------

Phone:	Alternate Phone:
--------	------------------

Licensure and Authorization Information

Applicants must provide information regarding their registered nursing license.

What state/jurisdiction do you hold your RN license? _____ RN License Number: _____	I declare _____ as my primary state of residency.
---	---

Please select the APRN role for which you are seeking reinstatement of authorization.
You must submit a separate application for each authorization.

- ☐ Certified Nurse Practitioner (Psychiatric/Mental Health, Family, Pediatric, Neonatal, Women's Health, or Adult Gerontology)
☐ Certified Registered Nurse Anesthetist ☐ Clinical Nurse Specialist-Psychiatric/Mental Health
☐ Clinical Nurse Specialist ☐ Certified Nurse Midwife

APRN Certification Information

Applicants must provide verification of national certification from one of the certifying bodies listed in Board Rule 410-11-.12.

Name of National Certifying Body:	
National Certification Number:	Date of Certification:

APRN Nursing Education Information					
To ensure that our licensure records contain all information regarding your APRN education, please complete the section below.					
APRN School Name:					
Location of APRN Education Program:	City:	State:	Zip:		
Date of Graduation:	Degree Awarded: <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate <input type="checkbox"/> Other				
Active Practice Information					
Board Rules Chapter 410-11 require that applicants document one of the following:					
I have graduated from an advanced practice nursing education program within the four (4) years preceding the date of this application: <div style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</div>					
I have practiced as an advanced practice registered nurse (based on the definition of "Advanced Practice Nursing" found in O.C.G.A. §43-26-3) at least five hundred (500) hours within the four (4) years preceding the date of this application and have provided the employment information on the grid below: <div style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</div>					
Employer Name and Address	Location (City/State)	Position/Title	Dates of Employment (Month/Year to Month/Year)	APRN Licensure Required	Number of Hours Worked
A completed verification of employment form must be submitted for each employer listed on this grid. If your employer uses a third party to verify employment it is the applicant's responsibility to obtain the employment documentation and submit it with the application packet.					
I have completed a Board Approved Reentry Program as defined in Board Rule 410-4-.04. <div style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</div>					

Applicants that have not met the active practice requirement within the previous four years by graduating from an advanced practice nursing education program or practicing at least five hundred hours must complete a Board approved reentry program as defined in Board Rule 410-4-.04.

Criminal and Disciplinary Information

Failure to reveal an offense, arrest, ticket, or citation may subject your license to a disciplinary order and fine.

Have you ever been arrested? ☐ No ☐ Yes

Note: The answer to this question is "Yes" if an arrest or conviction has been pardoned, expunged, dismissed, or deferred, you pled and completed probation under First Offender, and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.

Has any licensing authority in Georgia or any other jurisdiction ever refused to issue you a license or ever revoked, annulled, canceled, accepted the surrender of, suspended, placed on probation, or refused to renew a professional license, certificate, or multi-state privilege held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?

☐ No ☐ Yes

Within the past five (5) years have you been addicted to and/or treated for the use of alcohol or any other drug? ☐ No ☐ Yes

Are you currently under investigation or is a disciplinary action pending against your nursing license or any other license or certification you hold in any state or territory of the United States?

☐ No ☐ Yes

Are you currently a participant in a state board/designee monitoring program including an alternative to discipline, diversion, or a peer assistance program?

☐ No ☐ Yes

Have you ever been terminated from an alternative to discipline, diversion, or a peer assistance program due to unsuccessful completion?

☐ No ☐ Yes

Do you currently possess any condition that may in any way impair your ability to practice or otherwise alter your behavior as it relates to the practice of nursing?

☐ No ☐ Yes

Citizenship and Immigration

Georgia law requires applicants to submit a copy of their Secure and Verifiable Document. This includes a copy of your driver's license, United States Passport, or a copy of your current immigration document(s) which includes your alien identification number, I-94 number, and SEVIS ID if required.

A complete list of secure and verifiable documents published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status. This list may be found on the Board's website at this address: <https://sos.ga.gov/page/secure-and-verifiable-documents>

1) _____ I am a United States citizen 18 years of age or older. Please submit a copy of your current Secure and Verifiable Document(s) such as your driver's license, passport, or other document as indicated on page 9 of the application packet.

2) _____ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, your SEVIS number.

Under penalties of perjury, I understand that any false or misleading information in, or in connection with my application, may be cause for denial or revocation of licensure. In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia Board of Nursing and/or criminal prosecution.

Applicant Affidavit

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia Board of Nursing, and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

Applicant Signature

Date

Sworn to and subscribed before me this _____ day of _____, 20_____.

Signature of Notary Public

Commission Expiration Date

- THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY -

Application Checklist

To ensure that your application is complete, please use the following checklist:

Enclose a check or money order payable to the Georgia Board of Nursing in the amount of \$90 application fee + \$10 processing fee = \$100. Remember—application fees are nonrefundable.

Enclose a completed verification of employment.

Enclose secure and verifiable documentation of United States citizenship or legal immigration status.

Request your national certifying body to provide verification of national certification as an advanced practice registered nurse to the Board. Verification of certification should be submitted electronically from the certifying body to nursing@sos.ga.gov.

If you hold an RN license in any compact state other than Georgia, request verification of RN licensure be made available to the Georgia Board of Nursing by visiting www.nursys.com. Paper verifications are only accepted from jurisdictions that do not provide verifications through Nursys.com.

Submit your completed application to: Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217

You may check your application status by visiting the Board's website at <https://sos.ga.gov/georgia-board-nursing>. Select "Check Application Status" under Licensing Service.

GEORGIA BOARD OF NURSING

237 Coliseum Drive
Macon, Georgia 31217

VERIFICATION OF EMPLOYMENT FOR APPLICANTS FOR REINSTATEMENT OF AUTHORIZATION**Section I (To be completed by applicant)**

Submit this form to your employer to verify your employment and the number of hours worked. The name and address of your employer on this form must match the name and address you listed under "Employment History" on your application. Ask the employer to complete this form and place it in a sealed envelope for you to submit with your application or submit it by email to nursing@sos.ga.gov.

Last Name:

First Name:

Physical Address:

City:

State:

Zip:

Phone:

Email:

I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia Board of Nursing. I understand this information is required as part of the application for licensure process.

Applicant Signature_____
Date**Section II (To be completed by employer)**

Please complete the form in its entirety. Be sure to accurately document the employee's position/title and whether or not licensure as a registered nurse was required. The completed and notarized form may be provided to the applicant or submitted directly to the Georgia Board of Nursing by email to nursing@sos.ga.gov.

Facility/Business/Employer Name:

Physical Address:

City:

State:

Zip:

Phone:

Email:

Employer Information:

Is this a federal agency of the United States Government? ☐ No Yes ☐Is this an acute care inpatient hospital? ☐ No Yes ☐Is this a long term acute care facility (LTAC)? ☐ No Yes ☐Is this an ambulatory surgical center or obstetrical facility as defined in O.C.G.A. §31-6-2? ☐ No Yes ☐Is this a skilled nursing facility which has at least one hundred (100) beds and provides health care to patients with similar health care needs as those patients in a long term acute care facility? ☐ No Yes ☐

Employee's Position/Title:

Is an APRN license a qualification/requirement for employment in this position? ☐ No Yes ☐

If different location of the employer listed on the first page, please identify the physical location where the employee practiced		
Facility/Business/Employer Name:		
Physical Address:		
City:	State:	Zip:
Phone:	Email:	
Dates of Employment: Employed From _____ (Month/Year) to _____ (Month/Year) Were there any periods of extended absence during employment? <input type="checkbox"/> No Yes <input type="checkbox"/> If yes, please provide dates" _____ (Month/Year) to _____ (Month/Year)		
Please complete the grid below:		
Year	Hours Worked	Job Title/Description

Name and title of individual verifying employment information:	
I hereby certify that I am the custodian of records at the facility listed on this form and the information submitted on this form are true and correct statements of this applicant's employment with our facility. <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%; text-align: center;"> _____ Signature </div> <div style="width: 45%; text-align: center;"> _____ Date </div> </div> <div style="margin-top: 10px;"> Sworn to and subscribed before me this _____ day of _____, 20_____. </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%; text-align: center;"> _____ Signature of Notary Public </div> <div style="width: 45%; text-align: center;"> _____ Commission Expiration Date </div> </div>	