GOBIERNO DE PUERTO RICO

Departamento de Salud

COMMONWALTH OF PUERTO RICO
DEPARTMENT OF HEALTH
BOARD OF NURSE EXAMINERS

APPLICATION FOR NURSE LICENSE ENDORSEMENT
OF REGISTERED/PRACTICAL NURSE LICENSE

REPROCITY AND ENDORSMENT

Affidavit Num._____

State or Territory of _____

Town or City of _____

2'' x 2'' Autographed Photo

I HEREBY CERTIFY, That the preceding information is true and correct, that no charge has ever been brought against the applicant for professional or moral misconduct, that the applicant has never been convicted of, nor indicted for, any crime. The attached photograph is a true likeness of applicant taken within the past six months.

_____
(Signature of Applicant)

NOTARIAL SEAL

Subscribed and sworn before me this _____ day of _____ 20 _____ Witness my hand and seal hereunto attached.

_____
(Signature of Public Notary)

A. PERSONAL AND ACADEMIC HISTORY

1. Name_____
2. Residential Address _____
   Postal Address _____
   Zip Code _____ Phone _____ E-mail _____
3. Date and Place of Birth _____
4. Citizenship _____ Social Security Num._____
5. Have you ever practiced nursing illegally? _____ Have you ever been convicted of, or indicted for, any crime? _____ if so, state facts of the case on separate sheet and attach.
6. Have there been any changes in your original name? _____ if yes, explain and give your previous name_____
7. Did you finish High School? Yes _____ No _____
   High School Information _____
   (Graduation year – Name of School)
8. If you have obtained your High School Diploma through an Aptitude Test, please Indicate year and place where you obtained it. _____

B. NURSING EDUCATION PROGRAM CERTIFICATION
(The Director of the School or his/her designee shall fill out this part)

1. Applicant's Name _____
2. School of Nursing _____
3. Postal Address _____
4. Kind of Program Offered _____
5. Date of Admission:_____
6. Date On Which Program was Completed:_____

I hereby certify that this information is true and correct as it appears from applicant record, whose name appears in space B-1 that the program had a duration of not less than _____ calendar years, that applicant completed the program and received an academic grade (or diploma) to that effect. I hereby further certify as to applicant's moral solvency.

(OFFICIAL SEAL OF INSTITUTION)

Name _____
Title _____
Date _____
Signature _____

C. ADDITIONAL EDUCATION, IF ANY: _____

D. PERSONAL REFERENCES:
(Include the signature of two professional nurses who have known applicant for at least two years)

1. Name_____
   Postal Address_____
   License Num. _____ Where obtained (Country/State) _____
   License Category_____ Signature _____

2. Name _____
   Postal Address_____
   License Num._____ Where obtained (Country/State) _____
   License Category _____ Signature _____

E. HEALTH CERTIFICATE

I hereby certify that the applicant _____

HAS BEEN EXAMINED and found in good physical and mental health.

License Num._____ _____
(Physician Signature)

_____ _____
(Postal Address) (Physician Name)

_____ _____
(Telephone)

F. RESULT OF EXMINATION AND ACTION TAKEN ON ISSUANCE OF LICENSE (To be filled out by the Board of Nurse Examiners)

(DO NOT WRITE IN THIS SPACE. TO BE COMPLETED BY THE BOARD)

	1st Exam. Date		2nd Exam. Date		3rd Exam. Date	
SUBJECTS	**Approved**	**Not Approved**	**Approved**	**Not Approved**	**Approved**	**Not Approved**
Pediatric Nursing	_____	_____	_____	_____	_____	_____
Medical and Surgical Nursing	_____	_____	_____	_____	_____	_____
Obstetric Nursing	_____	_____	_____	_____	_____	_____
Mental Health And Psychiatric Nursing	_____	_____	_____	_____	_____	_____

1. Application received _____
2. Provisional license granted _____
3. Provisional license cancelled _____
4. License endorsement granted on _____
5. License category and number _____

Signature of Board Members

_____ _____

_____ _____

_____ _____

LICENSURE VERIFICATION FORM

PART I: TO BE COMPLETED BY APPLICANT

Complete this part and submit a copy to each state where you hold or have ever held a license to practice nursing making copies of this form as necessary.

Applicant Name_____ SS# _____

Address _____

License Number _____ State _____
(U.S Territory**)**

I hereby authorize release of any information regarding my license to the Puerto Rico Board of Nursing.

PART II: TO BE COMPLETED BY AN OFFICIAL OF LICENSURE BOARD

Please complete this part and return this form to the address listed below.

Licensed Name: _____ Profession: _____

License/Certification Num.: _____ Issued Date: _____

License Status: _____ Expiration Date: _____

Issuance Based On:

State Exam _____ National Exam _____

NCLEX Exam _____

Reciprocity with _____ Endorsement _____

IS LICENSE/CERTIFICATION IN GOOD STANDING _____

HAS THE LICENSE/CERTIFICATION EVER BEEN REVOKED OR SUSPENDED? _____

ANY DEROGATORY INFORMATION ON FILE? _____

REMARKS:_____

THE NURSING BOARD OF _____ WILL GRANT AN ENDORSEMENT LICENSE, TO THE NURSES OF PUERTO RICO, IF THE NURSE COMPLIES WITH ALL THE REQUIREMENTS OF THE STATE BOARD OF NURSING.

VERIFIED BY: _____
Signature of Official

BOARD SEAL

_____
Name and Title

STATE: _____ _____
Date Signed

Puerto Rico Board of
Nurse Examiners
PO Box 10200
Santurce, Puerto Rico 00908
Telephone (787) 999-8989

INSTRUCTIONS

TO AVOID DELAY IN THE PROCESSING OF THE ENDORSEMENT APPLICATION AND THE ASSURANCE OF A LICENSE, PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY:

1. Print or type all information on this form, except signatures.
2. Applicant's address should be as precise as possible, so as to assure mail delivery.
3. The certification of the educational program should be completed by the Schools, Institution Director or by the person authorized thereby.
4. The official seal of the school or control institution must be included in the space provided for said purpose.
5. The legal certification or affidavit should be executed by an attorney who is a Public Notary or by a judge. The legal certification shall be subscribed after all the other information has been written on this document and the required photograph has been attached hereto. ******If affidavit were to be completed in the U.S. it must be submitted with a County Clerk state certification***. ***
6. The photograph shall be a professional 2''x 2'' in size, signed in ink by the applicant facing front, taking care that the face is not marked by any letter.
7. The persons appearing as references shall sign personally on the corresponding line.
8. These documents shall be sent by applicant or by the Nursing School / Institution directly to the Puerto Rico Board of Nurse Examiners:
   - **a.** Copy of high school diploma or certification.
   - **b.** High school official transcripts (Only Practical Nurse).
   - **c.** If high school studies were taken in a foreign country you must submit the transcript to the Department of Education of P.R. for a certification of grade equivalence. (Transcripts must be sent directly to the Board by the school; transcripts must explain their academic evaluation system.)
   - **d.** Copy of nursing diploma.
   - **e.** Copy of nursing license.
   - **f.** Official nursing transcripts (transcripts must be sent directly to the Board by the School or Institution; transcripts must explain their academic evaluation system, the content and level of each course and the number of hours).
   - **g.** Certificate of no criminal record from the Puerto Rico Police Department and from the place of residence during the last five years.

h. Original and copy of birth certificate.

i. Foreign professionals must submit evidence of residence, citizenship or passport.

j. Money order in the amount of $80.00, payable to the Secretary of the Treasury of Puerto Rico and enclosed with application.

k. Official license certification from the State Board that issued your nursing license. Must be send directly to the Board, see Licensure Verification Form enclosed.

l. Official certification of the **NCLEX** Examination results. Must be sent directly to the Board from the National Council of Licensure Examination.

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

Oficina de Reglamentación y Certificación de los Profesionales de la Salud
PO BOX 10200 San Juan, PR 00908-0200
WWW.SALUD.GOV.PR, (787)765-2929 Ext. 6533