



Virginia Department of  
**Health Professions**  
Board of Nursing

9960 Mayland Drive  
Suite 300  
Perimeter Center  
Henrico, Virginia 23233  
(804) 367-4515 [www.dhp.virginia.gov/nursing](http://www.dhp.virginia.gov/nursing)

**CHECKLIST INSTRUCTIONS FOR REINSTATEMENT APPLICATION FOLLOWING SUSPENSION OR REVOCATION**

**Check One or Both (if applicable):**

LNP (\$200)     Prescriptive Authority (\$85)

Pursuant to Virginia nursing regulation [18 VAC 90-30-110](#) and [18 VAC 90-40-60](#) a Nurse Practitioner whose license and/or license with Prescriptive Authority was suspended or revoked may apply for reinstatement. If previous license(s) revoked, **must wait until three (3) years have elapsed from the revocation order entry date.**

**Note:** Virginia is a *compact* state under the Enhanced Nurse Licensure Compact (eNLC). Under the eNLC, to receive and/or maintain an RN/LPN license with *multi-state privilege(s)*, an applicant must meet all *Uniform Licensure Requirements* in accordance with [Virginia Code § 54.1-3040.3 C](#). If you do not meet all **Uniform Licensure Requirements** (ULRs) OR you reside in a 'non-compact' state, you may be eligible for a single-state license authorizing practice only in Virginia.

If your **primary state of residence (PSOR)** is a **compact** state, you must apply for licensure in your PSOR (compact state). If your primary state of residence is Virginia or a non-compact state, and your Virginia license has been **expired for more than two years**, you may apply in Virginia for reinstatement. Indicate on the application your primary state of residence. **For current information on the NLC go to:** <https://www.ncsbn.org/nurse-licensure-compact.htm>.

**REQUIREMENTS BELOW - Check applicable COMPLETED items that are included with your application:**

<input type="checkbox"/>	<b>Completed Reinstatement Application and required Fee(s):</b> Fees must be paid by check or money order, made payable to <i>The Treasurer of Virginia</i> . An application will not be reviewed or considered until payment is submitted. <b>Fees are non-refundable.</b>
<input type="checkbox"/>	<b>Current license as a registered nurse in Virginia or a current multistate licensure privilege as a registered nurse:</b> must meet this requirement to be eligible to reinstate a nurse practitioner license.
<input type="checkbox"/>	<b>Current professional certification in the specialty area of practice issued by the appropriate certifying agency identified in <a href="#">18 VAC 90-30-90</a>.</b>
<input type="checkbox"/>	<b>Completed continuing education requirements</b> while license(s) suspended/revoked required for licensure renewal in accordance with <a href="#">18 VAC 90-30-105</a> and <a href="#">18 VAC 90-40-55</a> during suspension/revocation period. <b>*For prescriptive authority:</b> you must have also completed two hours of CEs in pain management, proper prescribing of controlled substances, diagnosis and management of addiction mandated in <a href="#">Virginia Code § 54.1-2912.1</a> .

Additional Information:

**The VBON may request additional evidence that the nurse is prepared to resume practice in a safe, competent manner.**

Nursing laws and regulations may be obtained at [www.dhp.virginia.gov/nursing](http://www.dhp.virginia.gov/nursing).

Documents submitted with the application are property of the Board and cannot be returned.

**THIS APPLICATION CHECKLIST MUST BE RETURNED WITH APPLICATION**



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**APPLICATION – REINSTATEMENT FOR NURSE PRACTITIONER AND/OR PRESCRIPTIVE AUTHORITY FOLLOWING  
SUSPENSION OR REVOCATION**

**FOR OFFICE USE ONLY (FINANCE DIVISION)**

**FOR OFFICE USE ONLY (VBON STAFF)**

<b>Fee paid/Check one/both:</b> <input type="checkbox"/> LNP (\$200) <input type="checkbox"/> Pres. Auth (\$85)	<b>Applicant ID#:</b>	<b>Receipt #:</b>	<b>Approved:</b>	<b>Date:</b>
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I hereby make application to reinstate my nurse practitioner and/or prescriptive authority license(s) in the Commonwealth of Virginia. The following information in support of my application is submitted with a **check or money order** made payable to the *Treasurer of Virginia*. **The fees are non-refundable.**

**Disclosure of Addresses**

Pursuant to [Virginia Code § 54.1-2400.02](#) addresses of licensees are made available to the public. Normally, the Address of Record is the publicly disclosed address. If you do not want your Address of Record to be made public, you may provide a second, publicly disclosable address (e.g. work or practice address). If you would like your Address of Record to be publicly available complete both sections with same address.

**Disclosure of Social Security or DMV Control Numbers**

Pursuant to [Virginia Code § 54.1-116 \(A\)](#), you are required to submit your social security number or your control number issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.

<b>1. APPLICANT INFORMATION</b> - provide the information requested below and on all pages. (Print or Type) <b>Use full name, not initials.</b>			<b>Applicant Type</b> (Check One or Both): <input type="checkbox"/> LNP <input type="checkbox"/> Pres. Auth.		
Name: Last	First	Middle/Maiden	Suffix		
Address of Record (Mailing Address)	City	State	Zip	Telephone Number	
Publicly Disclosable Address	City	State	Zip	Telephone Number	
Email Address:					
Date of Birth: ____ / ____ / _____		Social Security Number or Virginia DMV Control Number*:			
Virginia LNP and/or Pres. Auth. License Number(s):		Full Name at Time of Initial Licensure:			
<b>DECLARATION OF PRIMARY STATE OF RESIDENCE</b>					
I declare that the <b>state</b> of: <input type="text"/> is my <b>Primary State of Residence</b> and that such constitutes my permanent and principal home for legal purposes. (*If not VA, refer to <b>Compact</b> info on the <b>Instruction</b> page).					

**2. EMPLOYMENT INFORMATION**

If employed, list your <b>current</b> Employer and job title:	Employer:	Job Title (position title):
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**3. LICENSURE HISTORY/QUESTIONS (pertains to any license or certificate ever issued to applicant)**

**CURRENT LICENSE INFORMATION**

I hold an **ACTIVE** (Check Applicable Items):

<input type="checkbox"/>	Virginia RN License #:	Expiration Date:
<input type="checkbox"/>	Compact Multi-State RN License #:	State: Expiration Date:
<input type="checkbox"/>	NP, APRN, NP w/Pres. Auth. or equivalent certification/registration #:	State: Expiration Date:

• List **current** state(s) of practice:

Answer **YES** or **NO** to *EACH* of the following:

1. Have you ever had disciplinary action taken against **any** license/registration/certificate to practice in a state or against your multi-state privilege to practice in a state? YES  NO
2. Have you ever voluntarily surrendered **any** license/registration/certificate or multi-state privilege issued to you to avoid disciplinary action? (Does not include allowing your license to expire or placing the license in inactive status.) YES  NO
3. Have you ever had any of the following disciplinary actions taken against your license/registration/certificate or multi-state privilege by any licensing authority in any jurisdiction: placed on probation, suspended, revoked or otherwise disciplined? YES  NO
4. Have you ever applied for and been denied a license/registration/certificate or multi-state privilege in a health related field or jurisdiction? YES  NO
5. Have you ever been the subject of an investigation by **any** licensing authority? YES  NO
6. Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence and reckless driving but excluding other traffic violations)? \*YES  NO  **\*Information Previously provided**
7. Within the past five (5) years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? YES  NO 
  - A. If YES, detail under **Explanation** section.
  - B. Within the past five (5) years, have you sought or been directed to seek treatment for your conduct or behavior? YES  NO
8. Within the past five (5) years, have you been disciplined by any entity? YES  NO 
  - A. If YES, detail under **Explanation** section and provide any associated orders or letter from entity.
  - B. Within the past five (5) years, have you sought or been directed to seek treatment for your conduct or behavior? YES  NO
9. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing nurse. YES  NO 
  - A. If YES, detail under **Explanation** section. (**Note:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board).

**LICENSURE HISTORY/QUESTIONS CONTINUED**

Answer **YES** or **NO** to *EACH* of the following:

10. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing nurse.  
 YES  NO   
 A. If YES, detail under **Explanation** section. (**Note:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board).
11. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing nurse.  
 YES  NO   
 A. If YES, detail under **Explanation** section. (**Note:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board).
12. Within the past five (5) years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? YES  NO   
 A. If YES, detail under **Explanation** section. (**Note:** The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application or have the program send this documentation directly to the Board).

**4. MILITARY QUESTION(S):**

13. Are you an active member or veteran of the U.S. military? YES  NO
14. Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? YES  NO

5. List all of your employers since your license was suspended or revoked. Include addresses, telephone number, dates of employment and reason for leaving:

Employer Name (Current/Most Recent Employer First)	City/State	Employment Start Date	Employment End Date	Reason for Leaving

6. List any educational offerings you have participated in since your license was suspended or revoked.

Name of Education Offering or Program	Dates of Participation

**EXPLANATIONS (If no information provide here: line through Section; or Attach additional pages if necessary):**


**CERTIFICATION**

I certify by entering my signature below, I am the person applying for licensure and meet the qualifications required by Virginia law and regulations and I have entered into a written or electronic practice agreement in accordance with [Virginia Code §54.1-2957](#) and [Virginia Code §54.1-2957.01](#), if applicable. Further, I certify the information provided in this application has been personally provided and reviewed by me and that statements made on the application are true and complete. I understand that providing false or misleading information as well as omitting information in response to information requested in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license.

<b>Signature:</b>	<b>Date:</b>
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