



ALASKA BOARD OF NURSING
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
550 WEST 7TH AVENUE, SUITE 1500
ANCHORAGE, AK 99501
TELEPHONE: (907) 269-8161 Fax (907) 269-8196
E-mail: license@alaska.gov

ADVANCED NURSE PRACTITIONER PRECEPTORSHIP REGISTRATION

If you received this application other than directly from the Division or its official website, the application may be outdated or not an official version. To ensure you have the official version, please contact the Division.

Advanced Nurse Practitioner is defined by statute as "a registered nurse authorized to practice in the state who, because of specialized education and experience, is certified to perform acts of medical diagnosis and the prescription and dispensing of medical, therapeutic, or corrective measures under regulations adopted by the board;" (AS 08.68.410(1)).

According to 12 AAC 44.460, the board will, in its discretion, register an applicant to engage in clinical practice in order to complete a course of study based outside of Alaska that meets the requirements of 12 AAC 44.400(a)(1)(A).

An applicant for initial authorization to practice as an advanced nurse practitioner as defined in AS 08.68.410(1) and 12 AAC 44.400

- (1) must have satisfactorily completed
 - (A) a formal accredited graduate educational course of study in nursing that
 - (i) is a minimum of one academic year in length,
 - (ii) prepares registered nurses to perform an expanded role in the delivery of health care;
 - (iii) includes a combination of classroom instruction and a minimum of 500 separate, non-duplicated hours of supervised clinical practice,
 - (iv) If completed on or after January 1, 1998 has distinct course offerings of three graduate credits or more in advanced pathophysiology, advanced pharmacotherapeutics, and advanced physical assessment.

REQUIREMENTS AND PROCEDURES – 12 AAC 44.460

1. Submit a completed application for preceptorship registration and pay the required application fee. The application fee may be later applied towards application for permanent authorization as an Advanced Nurse Practitioner provided that the application is received before the expiration date of the preceptorship registration.
2. Verification of a current license in good standing to practice as a registered nurse by this state or another state licensing jurisdiction. (See enclosed form to be sent to another state board of nursing.)
3. Documented evidence of current enrollment in an advance nurse practitioner program. (In-progress transcripts are acceptable or written verification on college stationery sent directly from the nursing program director.)
4. Documented evidence of a preceptorship arrangement to be approved by the board. (Submit a copy of preceptorship agreement.)

CONDITIONS OF PRECEPTORSHIP PROGRAM

A registration expires and must be surrendered to the board 12 months from the date of issue or at the time the preceptorship arrangement is terminated, whichever occurs first.

A registration may be renewed one time if the applicant again meets the requirements of 12 AAC 44.460(b).

The board will, in its discretion, after a hearing under the Administrative Procedure Act (Alaska Statute 44.62), terminate the registration of a person registered under 12 AAC 44.460 who is found to have violated a provision of AS 08.68 or 12 AAC 44.

OTHER INFORMATION

Upon completion of the academic program for advanced nursing practice, you may apply for a temporary nonrenewable permit while waiting to take or receive the results from the national certifying examination. However, you must hold a current Alaska registered nurse license. Go to the Board's website at www.nursing.alaska.gov or contact the Alaska Board of Nursing office for an application for Advanced Nurse Practitioner Authorization for further instructions and requirements for the temporary permit.

Please be aware that the denial of an application for licensure may be reported to any person, professional licensing board, federal, state or local government agency, or other entity making a relevant inquiry or as may be required by law.



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FOR OFFICE USE ONLY

ADVANCED NURSE PRACTITIONER PRECEPTORSHIP REGISTRATION

\$ 50.00 ANP Preceptorship Registration Fee

1. Name: _____
Last First MI Maiden

2. Mailing Address: _____
Street Address or P.O. Box City State Zip Code

3. Social Security No.: _____ Date of Birth: _____
Required by AS 08.01.060. (If you are a foreign citizen unable to obtain a U.S. Social Security Number, contact the division for further instructions.)

E-mail Address: _____
(Please complete if you prefer to be notified of initial application status via e-mail.)

Current RN License No.: _____ Name of State: _____

Telephone No.: _____ Business Telephone No.: _____

4. **NURSE PRACTITIONER PROGRAM**

Didactic Program: _____ From _____ To _____

Preceptorship Served Under: _____

Name of Clinic and Address: _____

5. **Area of Specialty Practice**

CHECK THE APPROPRIATE BOX:

- Acute Care/Emergency Neonatal Family Psychiatric/Mental Health
- Adult Health Nurse Midwife Women's Health/OB-GYN
- Family Health Pediatric
- Gerontological Adult Psychiatric/Mental Health

6. List all state(s) where you hold or have held nursing licenses. Provide the state license number if available and status of license (current, inactive, lapsed, etc.). Indicate last name on license, if different than current name.

State	License No.	Expiration Date / Status

7. **DISCIPLINARY HISTORY:** The following must be answered pursuant to AS 08.68.270:

- 1. Has your professional license in any state or country ever been denied, revoked, suspended, stipulated, on probation, or been subject to any other restriction or disciplinary action? Yes No
- 2. Have you ever been convicted of **any** criminal offense other than a minor traffic violation (convictions include "suspended impositions of sentence")? Yes No
- 3. Have you ever been or are you currently the subject of an inquiry or under investigation by any state board or other licensing agency concerning a violation or alleged violation of any state regulation, statute, or for any violation or alleged violation of the Nursing Practice Act, or unprofessional or unethical conduct? Yes No

PERSONAL HISTORY: The following must be answered pursuant to AS 08.68.270:

- 4. Within the past five years, have you been or are you currently being treated, or on medication, for bipolar disorder, schizophrenia, paranoia, psychotic disorder, substance abuse, depression (excluding situational or reactive depression) or any other mental or emotional illness? Yes No
- 5. Within the past five years, have you been or are you addicted to, excessively used, or misused alcohol, narcotics, barbiturates or habit-forming drugs? Yes No
- 6. Within the past five years, have you had or do you have a physical disability or physical illness, which may impair or interfere with your ability to practice nursing? Yes No

If you answered "Yes" to any of the above questions, you must explain dates, locations, and circumstances on a separate piece of paper and send any supporting documents that are applicable (including court records, judgments, charging documents, etc.). If you answered "YES" to questions 4, 5 or 6, you must submit a statement from your health care provider indicating your ability to practice nursing.

Applications submitted without the appropriate attachments will be considered incomplete and will not be processed. All information contained in this application will be considered "public" unless required to remain confidential by law. Current licensee information, including mailing address, is available on the Board's website at www.nursing.alaska.gov under "License Search".

I hereby certify that the information provided in this application is true and correct to the best of my knowledge. I understand that any false or misleading information in this application or accompanying documents may result in failure to obtain authorization of subsequent revocation of my authorization to practice as an Advanced Nurse Practitioner.

SIGN HERE 

Signature of Applicant

(NOTARY SEAL)

SUBSCRIBED AND SWORN before me, a Notary Public in and for
the State of _____
this _____ day of _____, 20____.

SIGN HERE 

Signature of Notary Public
Notary Public in and for the State of _____
My Commission Expires: _____



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VERIFICATION OF NURSING LICENSE FOR ANP PRECEPTORSHIP

Section 1: APPLICANT - Complete Section 1 and mail to the state where you hold a CURRENT registered nurse license. **You do not need to complete this form if you have a current registered nurse license in Alaska.** Verifying state may charge a verification fee. If the state where you hold licensure is a member of the NURSYS System, please go on-line at www.nursys.com and register. **If you have already released your information via Nursys, you do not need to forward this form to the corresponding licensing board.**

I have released my license verification via the Nursys on-line verification system: Yes No

_____ (Last Name) (First) (Middle Initial) (Maiden)

Other Names: _____

Address: _____
 Street City State Zip Code

Birth Date: _____ Social Security No.: _____

License No.: _____ RN: _____ LPN: _____ Expiration Date: _____

Section II: BOARD OF NURSING - Please complete the applicable portions of this form on behalf of the nurse named above and return to the Alaska Board of Nursing at address at top of page.

Nursing School and Location: _____

Graduation Date: _____ Accredited: Yes No

Type of License: RN: _____ License No.: _____

Method of Licensure: Exam: _____ Endorsement: _____ Waiver: _____

Original Issue Date: _____ Expiration Date: _____

License Status: Current: _____ Inactive: _____ Lapsed: _____

Pending disciplinary action or pending investigation against this licensee? Yes No
 If "Yes," explain on reverse side of form.

Former disciplinary action: Has this license ever been ENCUMBERED in any way? Yes No
 If "Yes," dates: _____
 Explain: _____

VERIFICATION OF EXAMINATION AND SCORES

State Board Test Pool Exam: RN: _____ LPN: _____ Series: _____ Score: _____

Medical: _____ Psych.: _____ Obstetric: _____ Surgical: _____ Children: _____

NCLEX Scores: RN: _____ LPN: _____ Series: _____ Other: _____

NCLEX Scores: CAT RN: _____ LPN: _____ Date Taken: _____

Signature: _____ Title: _____

Board of Nursing: _____ Date: _____ BOARD SEAL