Arkansas State Board of Nursing

University Tower Building
1123 South University Avenue, Suite 800
Little Rock, Arkansas 72204

PHONE 501.686.2700
FAX 501.686.2714
www.arsbn.org

REFRESHER COURSE TEMPORARY PERMIT APPLICATION INSTRUCTIONS

1. The applicant must obtain a temporary permit.

2. Complete the Refresher Course Temporary Permit Application and submit it to the Board office. Use blue or black ink or type to complete the application.

3. Attach the $30.00 temporary permit fee to the application with a paperclip. In-state personal checks are accepted. Credit cards are accepted - see application for details. Please note that FEES ARE NON-REFUNDABLE.

4. Attach a copy of the acceptance letter from the refresher course.

5. Complete the Affidavit portion of the application before a Notary Public.

6. The temporary permit expires in **180 days** or upon completion of the Board approved refresher course. The temporary permit can only be used for activities directly related to the refresher course or competency-based orientation course. It may not be used for employment in any facility.

NOTE: All continuing education requirements must be met prior to issuance of an active license. If you are reinstating your nursing license from an inactive status after an absence of greater than five years you must have completed 20 practice-focused continuing education contact hours **OR** hold certification by a national certifying body recognized by the Arkansas State Board of Nursing **OR** completed an academic course in nursing or related field **AND** have completed an ASBN approved refresher course or an employer competency orientation program.

FOR OFFICE USE ONLY

FALSIFICATION OF THIS FORM IS GROUNDS FOR DISCIPLINARY ACTION AGAINST YOUR LICENSE.

ARKANSAS STATE BOARD OF NURSING

UNIVERSITY TOWER BUILDING
1123 SOUTH UNIVERSITY, SUITE 800
LITTLE ROCK, ARKANSAS 72204
501.686.2700 • 501.686.2714 fax • www.arsbn.org

NURSING REFRESHER COURSE TEMPORARY PERMIT APPLICATION

Full Name _____
(MISS, MS., MRS., OR MR) FIRST MIDDLE MAIDEN LAST

Address _____
STREET CITY STATE ZIP

Mailing address _____ E-mail _____
STREET/P.O.BOX CITY STATE ZIP

Date of Birth _____ Place of Birth _____
MONTH DAY YEAR CITY STATE

Social Security Number _____ Telephone number (____) _____

Name & Phone Number of Nearest Relative _____

ETHNIC INFORMATION (check one): ☐ African American ☐ Asian Indian ☐ Asian Other ☐ Hispanic
☐ Native American ☐ Pacific Islander ☐ White, not of Hispanic origin ☐ Other

Graduate of _____
NAME OF NURSING SCHOOL CITY STATE

Program Completion _____ _____
MONTH YEAR

Primary State of Residence _____ Initial State of Licensure _____

Type of inactive license(s) you hold: APRN ☐ RNP ☐ RN ☐ LPN ☐ LPTN ☐

State(s) and License Number(s) _____

Name license issued under: *(if different from above name, attach official documentation of name change)* _____

Have you ever been convicted of a misdemeanor or felony, pled guilty or nolo contendere to any charge in any state or jurisdiction? DWI's and similar offenses must be reported. (Traffic violations do not constitute a crime.) YES ☐ NO ☐
(If yes, please include a copy of the court docket, plea agreement or conviction papers, and evidence that fines, restitution are paid.)

Have you ever had any license, certificate, or registration disciplined (revoked, suspended, placed on probation, or reprimanded) or voluntarily surrendered in any state or jurisdiction? YES ☐ NO ☐
(If yes, include copy of Facts and Finding from Board and evidence of reinstatement of license)

Are you currently under investigation in any state or jurisdiction? YES ☐ NO ☐

Do you currently engage in drug-related behavior, including the use of mood-altering drugs/substances and/or alcohol that would affect your functional abilities to perform while working as a nurse? YES ☐ NO ☐

In the last two years, have you been the subject of a chemical or alcohol dependency intervention or participated in chemical or alcohol dependency treatment/rehabilitation? YES ☐ NO ☐
(If yes, submit all relevant documents, such as rehab program completion, support group meetings, drug screens, etc.)

REFRESHER COURSE

Program Name _____ Program Telephone No. _____ Enrollment Date _____

Program Address _____
STREET CITY STATE

Anticipated date of beginning clinical _____ Anticipated date of completion _____

FOR OFFICE USE ONLY
AR Cert. No. _____
Date _____

Temporary Permit **$ 30.00**

METHOD OF PAYMENT

☐ In-state personal check

☐ Money order/cashiers check

☐ Credit card

FEE IS NONREFUNDABLE

CREDIT CARD INFORMATION

Complete below if paying by credit card. There is a nominal processing fee (listed below) assessed with paying your fees by credit card. The Arkansas State Board of Nursing does not receive any portion of the processing fee.

Type of card Visa ☐ MasterCard ☐ Discover ☐

Cardholder's Name _____

Cardholder's billing address _____

_____
City State Zip

Credit Card # _____

Expiration date ____/____ Amount Paid _____
mm yyyy

Signature _____

*Processing fee - Temporary Permit - $0.90

AFFIDAVIT

State of _____

County of _____

_____ , being duly sworn, says he/she is the person who is referred to in the foregoing application for a Nursing Refresher Course Temporary Permit in the State of Arkansas; that the statements herein contained are true in every respect; that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit. I understand that if the processing of this application is not completed, the application becomes null and void one year from date received.

_____
Applicant's Signature

Sworn to before me this_____day of_____ 20 _____

_____
NOTARY PUBLIC

AFFIX NOTARY
SEAL HERE