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.
NURSING REFRESHER COURSE
TEMPORARY PERMIT APPLICATION

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

Full Name_________________________________________________________________________________________________ 

Address____________________________________________________________________________________________________

STREET________________________________________________________________________CITY____________STATE_____ZIP________________________

Mailing address________________________________________________________________________________________________

STREET/P.O. BOX______________________________________________________________CITY____________STATE_____ZIP________________________

Date of Birth___________________ Place of birth___________________ Social Security Number____________________________

Telephone Number (______)___________________Name and 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________________________________________________ Program Completion________________________________

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________________________________________________________________________________________________

Anticipated date of beginning clinical_________________________ Anticipated date of completion____________________________

FIRST MIDDLE MAIDEN LAST
STREET                     CITY STATE ZIP
STREET/P.O. BOX________________________CITY____________STATE_____ZIP________________________

STREET/P.O. BOX________________________CITY____________STATE_____ZIP________________________
# NURSING REFRESHER COURSE
## TEMPORARY PERMIT APPLICATION
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<table>
<thead>
<tr>
<th>METHOD OF PAYMENT</th>
<th>AFFIDAVIT</th>
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<tbody>
<tr>
<td>In-state personal check</td>
<td>State of __________________________ County of __________________________</td>
</tr>
<tr>
<td>Money order/cashier’s check</td>
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<tr>
<td>Credit card</td>
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</tbody>
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Complete below if paying by credit card. There is a nominal processing fee (listed below) assessed with paying your fee 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

Credit Card # | Expiration Date | Amount Paid

Signature

Diabetes Self-Management Educator Certification $25.00

*Processing fee – Diabetes Self-Management Educator Certification - $0.75

FEE IS NONREFUNDABLE

Sworn to before me this _____ day of __________, 20_____