Arkansas Department of Health

Arkansas State Board of Nursing
1123 S. University Ave., #800 • Little Rock, Arkansas 72204 • (501) 686-2700 • Fax (501) 686-2714
Governor Asa Hutchinson
José R. Romero, MD, Secretary of Health
Sue A. Tedford, MNSc, APRN, Director

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.

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NURSING REFRESHER COURSE
TEMPORARY PERMIT APPLICATION

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

Full Name_____
FIRST MIDDLE MAIDEN LAST

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_____

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NURSING REFRESHER COURSE
TEMPORARY PERMIT APPLICATION
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METHOD OF PAYMENT

_____In-state personal check ____Money order/cashier's check
_____Credit card

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

AFFIDAVIT

State of_____ County of_____

_____ , being duly sworn, says he/she is the person who is referred to in the foregoing application for certification as a Diabetes Self-Management Educator 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. I also understand that falsification of this form is grounds for discipline against my license.

Affix Notary Seal here

_____
APPLICANT'S SIGNATURE

_____
NOTARY PUBLIC

Sworn to before me this _____day of _____, 20_____
My Commission Expires_____