

NON-REFUNDABLE
FEE
\$75.00

MISSISSIPPI BOARD OF NURSING
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157
(601) 957-6300

Certified Hemodialysis Technician Reinstatement

Any statement made on this application which is false by the applicant at the time of making such statement shall be deemed fraudulent and will subject the applicant to disciplinary proceedings.

INSTRUCTIONS: Enter data and use dropdown boxes to make selections. The application must be completed, and the Authorization to Release must be notarized and submitted to the Board of Nursing. Submit the \$75.00 reinstatement fee with the application. Include your phone number and social security number on your payment. **Submit proof of current certification by the Nephrology Nursing Certification Commission (NNCC), National Nephrology Certification Organization (NNCO), or the Board of Nephrology Examiners for Nursing and Technology (BONENT).** Submit official evidence from employer of having worked as a CCHT within one (1) year preceding this application.

NAME:

First Middle Maiden Last

ADDRESS:

Box/Apt/Street City State Zip Code County

Mississippi CCHT #:

mm/dd/yyyy

NNCC/NNCO/BONENT Certification Status:

Expiration Date:

PHONE: (Home #)

(Alternate #)

EMAIL:

PLEASE SELECT CORRECT INFORMATION

GENDER	DATE OF BIRTH <small>mm/dd/yy</small>	MARITAL STATUS	ETHNICITY	HIGHEST DEGREE HELD
EMPLOYER				
NAME:				
Employer Name		City	State	County
EMPLOYMENT STATUS			MAJOR FIELD OF EMPLOYMENT	

I last worked as a CCHT on (date): mm/dd/yyyy in the State of

Since you last held an active Mississippi Certification, have you been disciplined by any disciplinary licensing board or agency or convicted of a felony or misdemeanor in any court of law (excluding speeding tickets), or are any charges currently pending against you?

If the answer to the above question is **“YES”**, attach a detailed explanation and **certified** copies of all pertinent records, including but not limited to, any and all court and/or regulatory agency records from the applicable state or jurisdiction. Allow additional time for **“YES”** answers to be reviewed.

By my signature below, I certify that I have read, understood, and that the above information is correct.

CCHT’s Signature: _____ **Date:** _____

Signature of Notary Public: _____ **My Commission Expires:** _____

(SEAL)

MISSISSIPPI BOARD OF NURSING
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157
(601) 957-6300

AUTHORIZATION TO RELEASE INFORMATION

Please read the following release form carefully. Enter your name in the blanks and your signature, and the date in the designated spaces. **THIS FORM MUST BE NOTARIZED.**

TO WHOM IT MAY CONCERN:

I, _____, hereby authorize any and all individuals and entities to release to the Mississippi Board of Nursing and its staff, personnel and/or agents, ***any and all records and information***, whether it be academic, military, medical, psychiatric, psychological, drug/alcohol treatment, employment (including, but not limited to, applications for employment, payroll information, incident reports, drug screens, alcohol screens, contracts for employment, dates and hours worked, dates and hours of absences, reasons for days missed, appraisals and reprimands, promotions, complaints, identity of supervisors, illnesses, injuries, and my reasons for termination or leaving), judicial (including, but not limited to, investigatory agency and court criminal and civil records), or personal reference, and I, _____, being competent to grant this release, ***hereby fully authorize the release of any and all such information, privileged or otherwise***, to the **Mississippi Board of Nursing** and its staff, personnel, representatives and/or agents and fully release any and all persons or parties from any and all charges or liability whatsoever because of furnishing or releasing said information and/or documents. I further authorize the Mississippi Board of Nursing to release any and all information, including but not limited to, the above referenced records to individuals/entities and/or Mississippi Board of Nursing-approved assessors the Mississippi Board of Nursing deems necessary. This release shall remain in full force and effect until revoked in writing.

SIGNATURE: _____

PRINTED NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE: _____

ATTORNEY'S SIGNATURE: _____
(if applicable)

STATE OF _____ COUNTY OF _____

Personally came and appeared before me, the undersigned authority in and for said county and state, the within named _____, who acknowledged to me that he/she signed and delivered the above and foregoing Authorization to Release Information form on the date therein mentioned and for the purpose therein expressed.

Given under my hand and seal of office, this the _____ day of _____ month _____ year.

NOTARY PUBLIC

MY COMMISSION EXPIRES

(SEAL)