

MISSISSIPPI BOARD OF NURSING
713 River Oaks Drive, Suite 300
Ridgeland, MS 39157
(601) 957-6300

LPN EXPANDED ROLE AUDIT COMPLIANCE

Any statement made on this application which is false and known to be false by the applicant at the time of making such statement shall be deemed fraudulent and is grounds for disciplinary action.

Per 30 Mississippi Administrative Code, Part 2840, Rule 3.1B(2) and 4.1B(2) Documentation of completion of a minimum of ten (10) contact hours of continuing education and/or in-service education in IV therapy and/or hemodialysis within the previous two (2) year period is required for renewal of the expanded role.

I am applying for (select one):

DATE: mm/dd/yyyy **Mississippi License # or Compact #:** **Primary State of Residence:**

NAME: First Middle Maiden Last

ADDRESS: Box/Apt/Street City State Zip Code

PHONE: (Home #) (Alternate #): **EMAIL:**

EMPLOYER: **NAME OF SUPERVISOR:**

EMPLOYER ADDRESS: Box/Street City State Zip Code County

CONTINUING EDUCATION RECORD: (Attach evidence of completion and submit along with this form)

IV THERAPY			
PROGRAM NAME	DATE(S)	NUMBER OF HOURS	SPONSORING AGENCY
HEMODIALYSIS			
PROGRAM NAME	DATE(S)	NUMBER OF HOURS	SPONSORING AGENCY

By my signature below, I certify that the information submitted is true and correct.

LPN's Signature: _____ **Date:** _____ **(SEAL)**

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

LPN Expanded Role Continuing Education Record

*Use this form if additional space is needed to list contact hours and submit it with evidence of completion if needed.

Name:

First

Middle

Maiden

Last

License #:

IV THERAPY			
PROGRAM NAME	DATE(S)	NUMBER OF HOURS	SPONSORING AGENCY

HEMODIALYSIS			
PROGRAM NAME	DATE(S)	NUMBER OF HOURS	SPONSORING AGENCY