



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

LPN REINSTATEMENT EXPANDED ROLE APPLICATION
INSTRUCTIONS

1. Complete entire application. (Incomplete applications will be returned.)
2. Enter data into form and use dropdown boxes to make selections.
3. **FEE:** Enclose \$20.00 (check or money order) payable to the Mississippi Board of Nursing. The certification reinstatement fee of twenty dollars (\$20) must be attached for each reinstatement certification selected. Include your phone number and social security number and/or nursing license number on your payment.
4. **IV THERAPY and/or HEMODIALYSIS:** Provide documentation of a minimum of ten (10) hours of continuing/service education related to IV Therapy, which were obtained within the previous two (2) year period if lapsed for less than two (2) years. (This must be documented on the continuing education record included in the application, and official evidence must be attached.); **OR**

Provide evidence of successful completion of a board approved IV therapy and/or hemodialysis course if lapsed for more than two (2) years. The course must include both theory and clinical.

The evidence of completion must include:

- The name and course provider and/or agency.
 - Name and dates of course and/or in-service.
 - Name, title, and signature of personnel responsible for course; and
 - The number of hours earned
5. The application must be notarized.
 7. **AUTHORIZATION TO RELEASE:** Form must be completed, **NOTARIZED** and returned directly to the Mississippi Board of Nursing.
 8. Send application and all required information to:
Attn: LPN Expanded Role
Mississippi Board of Nursing
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157

DO NOT RETURN THE INSTRUCTION PAGE TO THE MISSISSIPPI BOARD OF NURSING

NON-REFUNDABLE
FEE
\$20.00

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LPN EXPANDED ROLE REINSTATEMENT

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.

INSTRUCTIONS: Enter data and use dropdown boxes to make selections. The application must be completed, notarized and submitted to the board. Submit the \$20.00 reinstatement fee for each certification you are reinstating with this application. Include your phone number, social security number and/or nursing license number on your payment.

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: (TOTAL: Must be at least 10 hours for each certification selected; Attach evidence)

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

Since you last held an active Mississippi license, 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 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 information I provided 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 application 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

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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)

Revised 07/17/08