Nationwide Medical Licensing®

P.O. Box 1208
Melbourne, FL 32901
Phone: (888) 992-9933
Fax: (866) 437-8771

PLEASE COMPLETE EACH SECTION OF THIS PACKET THOROUGHLY. ANY OMITTED INFORMATION CAN CAUSE DELAYS IN PROCESSING YOUR APPLICATION. ATTACH ANY SUPPORTING DOCUMENTS YOU THINK MAY BE USEFUL (MEDICALDIPLOMA, TRAINING CERTIFICATES). PROVIDING THESE DOCUMENTS AHEAD OF TIME WILL REDUCE ANY DELAY IN REQUESTING YOUR VERIFICATIONS.

Full Name:

Have you ever used any other name? [ ] YES [ ] NO Please list: Married [ ] Single [ ]

Mother's Maiden Name: (Last Name Only)

Current address:

Work address:

Preferred Mailing Address: [ ] Home [ ] Work	Home Phone: ( ) Cell Phone: ( ) Work Phone ( )	Preferred Contact Number: [ ] Home [ ] Cell [ ] Work

Email Address:

Social Security Number:	Are you a U.S. Citizen? [ ] YES [ ] NO
Date of Birth: (MM/DD/YY)	Place of Birth: (City, State, Country)
Drivers License Number and State:	

Naturalization Date (if applicable):

PHYSICAL DATA:

Height:	Weight:	Gender:
Eye Color:	Hair Color:	Race:
Physical Marks:	Location of Marks:	

Have you ever been in the Military? [ ] YES [ ] NO

If Yes, list branch of service, rank, and dates of service. Indicate if discharge was honorable.

Branch:	Rank:	Type of Discharge:
Start Date:	End Date:	

EDUCATION

List education in chronological order. List all pre-professional/professional education

School/University	City/State	Course/Degree	MM/YY	MM/YY

Date of Graduation from Nursing School:

EXAMINATIONS List all nursing/advanced licensing examinations you have ever taken.			
Exam	**Date Taken (MM/YY)**	**State**	**Results (Pass/Fail)**

CERTIFICATION List all national advanced practice nursing specialty certifications.		
Are you certified by any Specialty Board? [ ] Yes [ ] No		
Name of Specialty Board	**Certification or Specialty**	**Date Certified & Exp. Date**

LICENSES Please list ALL nursing licensing ever held.			
State	**License Number**	**License Type**	**Issue Date/ Exp. Date**

EMPLOYMENT HISTORY

List in chronological order from date of completion of nursing education. Please include month/year and contact number. Be sure to address ALL gaps of employment larger than one month.

Employer:	Type of Employment:
City/State:	Contact Number ( )
DATES: (MM/YY) From:	TO:

Employer:	Type of Employment:
City/State:	Contact Number ( )
DATES: (MM/YY) From:	TO:

Employer:	Type of Employment:
City/State:	Contact Number ( )
DATES: (MM/YY) From:	TO:

Employer:	Type of Employment:
City/State:	Contact Number ( )
DATES: (MM/YY) From:	TO:

THIRD PARTY RELEASE INFORMATION Please list any and all names of individuals you wish Nationwide Medical Licensing to discuss the application and or any other personal information with on your behalf. If no party is listed, NML will ONLY speak directly with the nurse during the application process.	
Name/Title	**Contact Number**

ADVERSE ACTIONS / MALPRACTICE

Have you ever been treated or hospitalized for any mental illness, drug or alcohol abuse or do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
[ ] Yes [ ] No
If yes, please explain:

Have you ever had any adverse actions taken by a medical school, hospital, licensing board, or have you ever been charged with or found guilty of a violation of any national, federal, state, or local statute?
[ ] Yes [ ] No
If yes, please explain:

Have you been denied the privilege of taking an exam given by any licensing board?
[ ] Yes [ ] No

Have you ever been disciplined, dismissed or expelled from, had any admissions monitored or restricted, had privileges limited, suspended, terminated, put on probation, or requested to resign or withdraw from any of the below listed items:

- Any Hospital or similar institution. [ ] Yes [ ] No

- Any professional School or Training program. [ ] Yes [ ] No

Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or foreign jurisdiction limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you, or taken any other disciplinary action against you?

[ ] Yes [ ] No

Have you ever had your membership in or certification by any professional society or association suspended or revoked for any reason?

[ ] Yes [ ] No

Have you ever been names in a malpractice suit?
[ ] Yes [ ] No
If yes, please explain: (in addition, please be prepared to provide a copy of the complaint and settlement for each suit.)

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ACQUISITION AGREEMENT

I hereby acknowledge that I have attained the services of Nationwide Medical Licensing®, LLC for assistance with licensure in the state (s) of: (please list all states requested)

I understand that the fee for this service is $250.00 per state. This includes the cost of Nationwide Medical Licensing® administrating and processing of my License Application (s) and related documents. It does not include the fees charged by the regulatory board, various agencies that charge for direct source documentation, or postage/delivery fees. The direct source documentation will be invoiced upon completion of my application(s) and will be charged to the credit card listed below. I further understand that if I have chosen the Rush Service, this in no way effects the time in which the Medical Board will process my application but only refers to Nationwide Medical Licensing "IN-HOUSE" Rush. NML does not guarantee licensure by any specific date. By signing this agreement you acknowledge that you have read and understand the company policies outlined on our website

Total Payment Enclosed: $____________

Method of Payment:

_____ I paid online via Google Checkout
_____ I paid online via PayPal
_____ Company/Personal check or money order
_____ Credit Card
[ ] Visa
[ ] MasterCard
[ ] American Express
[ ] Discover

Cardholder Name: ______________________ Account Number _______________________
(As it appears on Card)

Security Number (CCV)_______ Expiration Date _______________________

Billing Address: ____

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________________________________ ________________________________
Signature Date

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Shipping Agreement

Nationwide Medical Licensing® uses USPS shipping method. In order for us to insure that your package gets to you on time and is delivered safely to you and you only, we request that you sign for your delivery. This is the safest way for your personal information to arrive to you and we strongly advise that you use this method of shipment. However, we do understand that there may be other circumstances that prevent you from being able to sign for your package. Therefore, please complete the following and select from the options below. Please understand that Nationwide Medical Licensing® cannot be responsible for those packages that are not signed for when delivered. This form must be filled out and returned before we are able to mail out any packages to you. Thank you.

Please check your option for shipping:

☐ I would like my package delivered to my home or office with no signature required. I understand that Nationwide Medical Licensing® is not liable for said package after it has been noted in the USPS tracking system that it has been delivered.

☐ I prefer my package to be delivered with signature required. I understand that I must sign for this package at the time of delivery.

____________________________ Signature

____________________________ Date