



Nationwide Medical Licensing®

2006 Vernon Place
Melbourne, FL 32901
Phone: (321) 622-9030
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 (MEDICAL DIPLOMA, 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? <input type="checkbox"/> YES <input type="checkbox"/> NO Please list:		Married <input type="checkbox"/> Single <input type="checkbox"/>
Mother's Maiden Name: (Last Name Only)		
Current address:		
Work address:		
Preferred Mailing Address: <input type="checkbox"/> Home <input type="checkbox"/> Work	Home Phone: () Cell Phone: () Work Phone ()	Preferred Contact Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Email Address:		
Social Security Number:	Are you a U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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. Starting with High School education.				
<u>School/University</u>	<u>City/State</u>	<u>Course/Degree</u>	<u>MM/DD/YY</u>	<u>MM/DD/YY</u>

Date of Graduation from Nursing School:

EXAMINATIONS

List all nursing/advanced licensing examinations you have ever taken.

<u>Exam</u>	<u>Date Taken (MM/DD/YY)</u>	<u>State</u>	<u>Results (Pass/Fail)</u>

CERTIFICATION

List all national advanced practice nursing specialty certifications.

Are you certified by any Specialty Board? [] Yes [] No

<u>Name of Specialty Board</u>	<u>Certification or Specialty</u>	<u>Date Certified & Exp. Date</u>

LICENSES

Please list ALL nursing licensing ever held.

<u>State</u>	<u>License Number</u>	<u>License Type</u>	<u>Issue Date/ Exp. Date</u>

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/DD/YY) From:	TO:

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

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

Employer:	Type of Employment:
City/State:	Contact Number ()
DATES: (MM/DD/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.

<u>Name/Title</u>	<u>Contact Number</u>

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.)