

RETAIN FOR REFERENCE

**Instructions
For Clinical Nurse Specialist (CNS) Applicants**

GENERAL INFORMATION:

- An applicant for Clinical Nurse Specialist certification must hold a current, unrestricted license as a registered nurse in this Commonwealth.
- An individual who meets the requirements of Section 3(b) of the Professional Nurse Law has the right to use the title "Clinical Nurse Specialist" and the abbreviation "CNS."
- If you hold or ever held CNS certification in Pennsylvania, your Pennsylvania certification must be reactivated. DO NOT PROCEED with this application.

INSTRUCTIONS:

- Mail the completed application and fee to the Board at the above address.
- All questions must be answered completely and all fees submitted in order for the application to be processed.
- To verify that the CNS certificate was issued visit www.licensepa.state.pa.us.
- Social Security Numbers must be provided.* If a Waiver of Social Security Number form is submitted in lieu of a Social Security Number, it cannot be used to renew a CNS certificate.
- Application must be received in the Board office within 90 days from the date the affidavit is signed.
- Applications are valid for one year from the date the affidavit is signed.
- If a CNS certificate is not issued within the one year, a new application, including fees, must be submitted.

FEES:

- The \$100 fee must be paid by personal check, cashier's check or money order and must be made payable to the "Commonwealth of Pennsylvania."
- **Fees are nonrefundable.**
- Check/money orders drawn on foreign banks are only acceptable when "US funds" is identified on the check/money order.
- A \$20.00 processing fee will be charged for a check/money order returned unpaid. Applications will not be processed until the corrected fee is received.

NAME / ADDRESS:

- Applicant's legal name must be entered on the application.
- CNS certificates are not forwarded.
- Complete and submit the "Form to Request Change of Name &/or Address ..." located on the Board's website, whenever there is a change of name &/or address. Licensees are responsible to advise the Board of any address or name change within 10 days of the change.

QUESTIONS: *If "YES" was checked for any question in Section B, submit:*

- A detailed, signed and dated personal explanation explaining the action, its background and any rehabilitation.
- A Criminal History Records Check (CHRC) from a State Law Enforcement Authority in all states where you lived in the last five years. All background check documents cannot be older than 90 days from the date of issuance. (Applicable ONLY to #B4 and #B5)
- Copies of criminal Court documents. (Applicable ONLY to #B4 and #B5)
- Certified copies of all disciplinary actions from the Boards that imposed action (Applicable ONLY to #B1, #B2 and #B3).

CHILD ABUSE CONTINUING EDUCATION REQUIREMENT:

EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete **3 hours** of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. Board approved providers may take up to 7 business days to electronically send verification of completion to the Board. A license will not be issued until this electronic verification is received.

[ACT 31 Mandated Child Abuse Recognition and Reporting Continuing Education Providers](#)

* Note that disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

LICENSURE REQUIREMENTS

An applicant for CNS certification must meet the following requirements:

1. Hold a graduate degree from a Board-approved or equivalent CNS program OR an educational program in a related discipline previously recognized for national certification as a CNS by the American Nurses Association or the American Nurses Credentialing Center.
2. Hold current national certification or its equivalence
 - National certification requires the passing of a national certifying examination in the specialty in which the applicant is seeking certification by the Board. Recognized national certification organizations include:
 - American Nurses Credentialing Center (ANCC)
 - American Association of Critical Care Nurses (AACN)
 - Orthopedic Nurses Certification Board (ONCB)
 - Oncology Nursing Certification Corporation (ONCC)
 - An applicant who is not eligible for national certification, must demonstrate BOTH that:
 - The applicant's educational program **does not** make the applicant eligible to take a national certification examination.
 - The applicant has experience in the CNS role through education and work history.

APPLICATION SUBMISSION REQUIREMENTS

1. Submit a completed **Application for Certification** as a CNS found at the Board's website and the \$100 fee to the Board.
 - If you do not have a Social Security Number, complete the *Waiver of Social Security Number* form. State the reason why you do not have a Social Security Number.
 - An **official transcript** must be mailed **directly** to the Board (ATTN: CRNP AREA) from the CNS education program that awarded the degree, certificate.
 - The CNS education program is the institution, school, college, or university where you completed the CNS education that qualified you for your original CNS license.
 - A **Non-official transcript**, such as a **student copy, or a student-submitted copy** that was provided to the student by the program in a sealed official envelope, is not acceptable.
 - The official transcript must designate the degree awarded with the month, day, and year the program was completed.
2. Have submitted a completed **Verification of Clinical Nurse Specialist Education**.
 - Forward the *Verification of Clinical Nurse Specialist Education Program* form to your CNS education program for completion.
 - The verification must be mailed **directly to the Board** from your CNS education program.
3. Have submitted a completed **Verification of National Certification** or its equivalence.
 - If you hold national certification:
 - Have your national certification organization send a verification of your certification **directly to the Board**.
 - Copies received from applicants are not acceptable.
 - If you are **not eligible** for national certification, forward the following to the Board:
 - Course descriptions from your CNS education program.
 - Current curriculum vitae.
 - Work history in the CNS role.
 - Three professional recommendations from individuals knowledgeable about the applicant's work experience in the CNS role.
 - Any additional advanced nursing education official transcripts.
 - Current national nursing certification(s).
4. If licensed as a CNS in another state or jurisdiction, have submitted a completed **Verification of Licensure**.
 - Complete Section A of the *Verification of Licensure* form and forward it to the jurisdiction where you hold a CNS license for completion.
 - The verification must be mailed **directly to the Board** from that jurisdiction.
 - Contact that jurisdiction directly about any fee charged for completion of the Verification.

SPECIALTY DESIGNATION

The specialty designation listed on the Pennsylvania CNS certificate will match the national certification designation. A CNS who is not eligible for national certification will receive the designation "without specialty" on the Pennsylvania CNS certificate.

MALPRACTICE INSURANCE REQUIREMENT

Once licensed, a CNS must maintain professional liability coverage at a level required for non-participating health care providers.

APPLICATION FOR CERTIFICATION AS A CLINICAL NURSE SPECIALIST (CNS)

Attach the **\$100 fee** and required documents. All fees are non-refundable.

SECTION A: APPLICANT INFORMATION: Print clearly in Blue or Black Ink Only.

Pennsylvania RN License Number: _____ Expiration Date: _____

Name: _____
 Last First Middle Maiden

 Please list any other name(s) appearing on official documents

Date of Birth: _____ U.S. Social Security Number: _____
 Month Day Year

Address: _____
 Street

 City State Zip

() _____ Email Address: _____
 Daytime Phone Number

SECTION B: QUESTIONS: ANSWER THE FOLLOWING QUESTIONS:

		YES	NO
1.	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
2.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3.	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
4.	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		

PENNSYLVANIA STATE BOARD OF NURSING

P.O. BOX 2649
HARRISBURG, PA 17105-2649

PHONE (717) 783-7142

FAX (717) 783-0822

www.dos.pa.gov/nurse

Email: st-nurse@pa.gov

Name: _____

SSN: _____

		YES	NO
5.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
6.	Do you currently engage in, or have you ever engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
7.	Have you ever had your DEA registration denied, revoked or restricted?		
8.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
9.	Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?		
10.	Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		

SECTION C: PROFESSIONAL INFORMATION:

		YES	NO
1.	Are you recognized as a Clinical Nurse Specialist (active or inactive status) by any other state?		
2.	Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?		

If you answered yes to the above question, please provide the profession and state or jurisdiction. Please do not abbreviate the profession.

STATE / COUNTRY	PROFESSION

If necessary, please attach a page with additional licensure information.

Name: _____

SSN: _____

SECTION D: CLINICAL NURSE SPECIALIST EDUCATION:

Type of Graduate Degree Awarded: Master's Post-Master's Doctorate _____ Other _____
(Select One) (Specify)

Full Name of the CNS Education program: _____
(No abbreviations)

City _____ State _____

Program Specialty: _____ Program Completion Date: _____
(mm/dd/yyyy)

SECTION E: CNS NATIONAL CERTIFICATION: (If you do not hold current national CNS certification also complete Section F)

Were you eligible to take a CNS national certification exam upon program completion? Yes _____ No _____

I hold Current National certification from _____ as a CNS in _____.
(National Certification Organization) (Specialty)

Expiration date: _____
(mm/dd/yyyy)

SECTION F: NATIONAL CERTIFICATION EQUIVALENCE ATTESTATION (Complete this section only if you do not hold current national certification)

This is to certify that I am not eligible to take any national CNS certification exam(s). I am not eligible for national certification as a clinical nurse specialist because: (state reason)

SECTION G: AFFIDAVIT: READ, SIGN AND DATE. ALL APPLICANTS MUST COMPLETE THIS SECTION.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Applicant's Full Legal Signature _____ Date _____

VALID FOR ONE YEAR

VERIFICATION of CLINICAL NURSE SPECIALIST EDUCATION PROGRAM

This form is to be completed in its entirety by the present Program Director or designee of the CNS Education Program AFTER ALL PROGRAM REQUIREMENTS HAVE BEEN MET.

Name of Graduate: _____ Date of Birth: _____ (MM/DD/YY)

Provide the last 4 numbers of the graduate's Social Security Number: XXX-XX- _____

Full Name of the College or University (no abbreviations): _____

Mailing Address: _____ (City) (State) (Zip Code)

Type of Program: CNS ___ Other _____ Program Specialty: _____

Date graduate completed the program: _____ Graduate Degree Awarded: _____ (MM/DD/YY) MSN, DNP, POST-MASTER'S, OTHER

Did completion of this program make graduates eligible to take a CNS national certification exam? Yes ___ No ___

If yes: National Certification Organization: _____ Specialty _____

Total number of clinical experience hours completed by this graduate: _____ Length of program: _____ (Months) Program Accreditation: CCNE ACEN _____

I certify that all of the above information is correct. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904 relating to unsworn falsification to authorities and may result in sanctions of my license or certificate and/or disposition of civil penalties. I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S. §4911.

X _____ Original Signature of Program Director/designee (Name stamp is not acceptable)

[SCHOOL SEAL]

_____ Print or type the name of Program Director/designee

_____ Program Director/designee's Contact Phone Number

_____ Date Signed

DO NOT RETURN THIS FORM TO APPLICANT. MAIL IT IN AN OFFICIAL SCHOOL ENVELOPE TO:

Pennsylvania State Board of Nursing
CNS Applications
P.O. Box 2649
Harrisburg, PA 17105-2649

Pennsylvania State Board of Nursing
2601 North Third Street
Harrisburg, PA 17110
(717) 783-7142

VERIFICATION OF CLINICAL NURSE SPECIALIST LICENSURE

Section A. Completed by Applicant only.

Name: _____ **Date of Birth:** _____
Last First Middle Maiden Name MM DD YYYY

Current Address: _____
Street City State Zip Code

Social Security Number: _____ - _____ - _____

Current Licensure/Certification: _____
State License Number

Section B. Completed by Original Licensing Authority only.

This is to certify that _____
Applicant's Name

was issued license/certification number _____ **as a CNS in the following**
Specialty: _____
(If Applicable)

Date Issued: _____ **Expiration Date** _____
(mm/dd/yyyy) (mm/dd/yyyy)

Current licensure/certification Status: Active Inactive Lapsed

Basis for Licensure: Endorsement National Certification Waiver Other: _____

Has this license ever been disciplined in any manner or are disciplinary charges pending? Check one:
 No Yes (If yes, please send certified copies of Board actions)

CNS/Advanced Nursing Education Program: _____

Location: (City, State/Province/Territory): _____

Program Completion Date: _____ **Specialty:** _____
(If Applicable)

Approved by State/Province/Territory: Yes No

Original Signature of Licensing Officer: _____

Title: _____

(SEAL) Name of _____ Licensing Authority: _____

Address: _____

Date: _____

DO NOT RETURN THIS FORM TO APPLICANT.

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