

INSTRUCTIONS FOR EXTENSION OF TEMPORARY PRACTICE PERMIT (TPP)

Notice: Application fee was increased on July 27, 2019.

ALL FEES ARE NON-REFUNDABLE.

The Board can only extend a TPP **IF** the specific deadlines below are met **AND** the holder has an illness or extreme hardship. Because illnesses or hardships cannot be anticipated, the Board recommends that all holders pay careful attention to the applicable deadlines.

Graduate Registered Nurses or Graduate Practical Nurses who hold TPPs and are seeking an extension shall:

AT LEAST **90 DAYS** PRIOR TO THE EXPIRATION DATE ON THE TPP:

- 1) Submit an application for licensure to the Board with the required fee.
- 2) Register to take the NCLEX at www.pearsonvue.com/nclex and pay the required fee.

AT LEAST **60 DAYS** PRIOR TO THE EXPIRATION DATE ON THE TPP:

- 1) Submit an *Application for Extension of TPP* to the Board with the appropriate fee.
- 2) Provide a signed and dated detailed written explanation about the illness or extreme hardship to justify the extension.
- 3) If the request is due to an illness, include certification from the treating healthcare provider with the application.

Registered Nurses or Practical Nurses who hold TPPs AND current licensure as RNs or LPNs in another jurisdiction of the United States or Canada and are seeking an extension shall:

AT LEAST **320 DAYS** PRIOR TO THE EXPIRATION DATE ON THE TPP:

- 1) Request that a *Verification of Licensure* from your original licensing authority be forwarded to the Board.
- 2) Submit a verification of your basic nursing education program.
 - a. If your basic nursing education was obtained in the U.S., U.S. territories or Canada - Request that your basic nursing education program forward an *Official Transcript* directly to the Board. The transcript must be in English.
 - b. If your basic nursing education program was obtained outside of the U.S., U.S. territories or Canada – Submit evidence that the applicant's program of study is deemed equivalent to the program of study required in the Commonwealth at the time the program was completed. The Board will base equivalency of the international nursing program upon an evaluation performed by a Board Approved Foreign Credentials Evaluator.
 - A list of Board-Approved Foreign Credentials Evaluators is on our Board website www.dos.pa.gov/nurse under the link: General Board Information. It is recommended you begin the process as soon as possible to reduce processing delays.

AT LEAST **90 DAYS** PRIOR TO THE EXPIRATION DATE ON THE TPP – The Board must receive a completed licensure application AND all supporting documentation. Please submit the application so that it arrives within this deadline.

AT LEAST **60 DAYS** PRIOR TO THE EXPIRATION DATE ON THE TPP:

- 1) Submit an *Application for Extension of TPP* to the Board with the appropriate fee.
- 2) Provide a signed and dated detailed written explanation about the illness or extreme hardship to justify the extension.
- 3) If the request is due to an illness, include certification from the treating healthcare provider with the application.

You will be notified by the Board if you have been granted an extension.

Submission of an application does not guarantee an extension
Retain dated copies of each requested document as proof that each was requested within the required deadlines.

NOTE: Disclosing your U.S. 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 U.S. Social Security Number. In addition, U.S. 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.

APPLICATION FOR EXTENSION OF TEMPORARY PRACTICE PERMIT (TPP)

\$85.00 FEE IS NON-REFUNDABLE

APPLICATION MUST BE SUBMITTED TO THE BOARD AT LEAST 60 DAYS PRIOR TO THE EXPIRATION OF THE TPP.

Applying For Extension of TPP: (Check only one)

Graduate Registered Nurse TPP# _____

Graduate Practical Nurse TPP# _____

Registered Nurse (RN) TPP# _____

Practical Nurse (PN) TPP# _____

EXPIRATION DATE OF TPP _____
(mm/dd/yyyy)

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

Name: _____
Last First Middle Maiden

List any other names you have used.

Address: _____
Street

City State Zip Country

() _____ Email Address: _____
Daytime Phone #

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

SECTION B: QUESTIONS: Please answer the following questions by choosing "YES" or "NO."

		YES	NO
1.	Have you ever failed the NCLEX® exam in any jurisdiction?		
2.	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?		
3.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
4.	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?		

		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?		

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 #B5)
- Copies of criminal Court documents. (Applicable ONLY to #B5)
- Certified copies of all disciplinary actions from the boards that imposed action (Applicable ONLY to #B2, #B3 and #B4).

SECTION C: PROFESSIONAL INFORMATION:

		YES	NO
1.	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.

APPLICANT NAME: _____ SS# _____ TPP# _____

SECTION E: 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 _____
(Original Signature)

ATTACH ALL REQUIRED DOCUMENTATION TO THE APPLICATION