

RETAIN FOR REFERENCE

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**General Instructions for Certified Registered Nurse Practitioner (CRNP) Certification Applicants**

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**An applicant for CRNP certification shall hold a current, unrestricted license as a professional nurse in this Commonwealth.**

“A CRNP practicing in this Commonwealth shall maintain a level of professional liability coverage as required for a nonparticipating health care provider under the act of March 20, 2002 (P.L.154, No. 13) known as the “Medical Care Availability and Reduction of Error (Mcare) Act...” (Professional Nursing Law Section 8.7).

Complete and mail the application to the Pennsylvania State Board of Nursing. Include the **fee** in the form of a personal check, cashier’s check or money order. Make fee payable to the **“Commonwealth of Pennsylvania.”** The fee is **nonrefundable**. Do not send cash. Charge cards are not accepted. A check/money order drawn on a foreign bank is not acceptable unless “US funds” is identified on the check/money order. A processing fee of \$20.00 will be charged for a check/money order returned unpaid. Forms received without the correct fee cannot be evaluated, and the applicant will be notified to submit the correct fee.

The application must be received in the Board office within ninety (90) days from the date the application is signed. The application is valid for one (1) year from the date signed. The process must be completed within the one-year time frame or the applicant will be required to submit a new application and fee. It is the responsibility of the applicant to submit all required documentation to the Board within the one-year time frame.

**Licenses are not forwarded.** Provide your current address to receive correspondence from the Board. It is the applicant’s responsibility to inform the Board of an address or name change within ten (10) days after the change. Refer to the “REQUEST FOR CHANGE” form located on our website.

For applicants who answer YES to question **1 of the Criminal/Disciplinary History** questions, the Board requires a detailed, signed and dated personal explanation from the applicant, Court documents and a recent Criminal History Records Check (**CHRC**) from the Pennsylvania State Police (**PSP**). The CHRC must be dated within six (6) months of the date the application is submitted. Contact the PSP for instructions and fee at [www.psp.state.pa.us](http://www.psp.state.pa.us). **For out-of-state applicants**, obtain a CHRC from every state where you lived in the last five (5) years. The CHRC must come from a State Law Enforcement Authority. Other documentation may be required by the Board after review.

For applicants who answer YES to question(s) **2 and/or 3 of the Criminal/Disciplinary History** questions, the Board requires a detailed, signed and dated personal explanation from the applicant. Also, contact the proper licensing authority where the action was taken and request that a certified copy of the order be sent directly to the PA Board.

Our goal is to process your application as quickly as possible. Please check the Pennsylvania State Board of Nursing verification website to verify if a license or certification was issued at [www.licensepa.state.pa.us](http://www.licensepa.state.pa.us).

If a Social Security number is not provided on the application and you are later issued a license, the license **cannot** be renewed until a Social Security number is provided. In order to comply with Federal Statute, the State Board of Nursing is obligated to inform each applicant or licensee from whom it requests a Social Security number that disclosing such number is mandatory in order for this Board 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). In order to enforce domestic support orders, at the request of the Commonwealth’s Department of Public Welfare (DPW), the licensing boards must provide to DPW information prescribed by DPW about the licensee, including the Social Security number. Additionally, disclosing the number is mandatory in order for this Board to comply with the requirements of the Federal Healthcare Integrity and Protection Data Bank. If this Board is required to make a report about one of its applicants or licensees to this Data Bank, it must report that individual’s Social Security number.

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## Requirement for approved training in child abuse recognition and reporting

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The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered “mandatory reporters” under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that 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. Please 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. [Child Abuse Continuing Education Providers Information can be found here.](#)

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**Instructions for Certified Registered Nurse Practitioner (CRNP) Certification Applicants**

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If you are seeking CRNP prescriptive authority, a separate application for CRNP prescriptive authority is required and can be obtained from the website.

1. A CRNP applicant must complete an accredited **Nurse Practitioner** program.
2. To be certified as a CRNP, the applicant must be currently certified as a Nurse Practitioner from a Board-recognized national certification organization,\* which requires the passing of a national certifying examination in the particular specialty in which the applicant is seeking certification by the Board. If certified/licensed after February 7, 2005, request that verification of your current national certification be sent directly to the PA State Board of Nursing from the national certification organization.

You will be required to maintain your national certification in order to renew your CRNP state certification. Request that verification of your current national certification is sent directly to the PA State Board of Nursing from the national certification organization. Copies are not acceptable. Verification is required to be sent to the Board for initial CRNP certification only. Thereafter, you will verify as Yes or No on the renewal application.

3. **PA Graduates:**
  - a. Complete Form 1.
  - b. Submit Form 2 to the Nurse Practitioner program you completed.
4. **Nurse Practitioners certified/licensed in another jurisdiction:**
  - a. Complete Form 1.
  - b. Submit Form 2 to the Nurse Practitioner program.
  - c. Submit Form 3 to your original licensing authority.

The Board may require documentation of the licensure or certification requirements at the time you were initially licensed/certified by the other jurisdiction. The Board will notify you or your NP Program Director if additional information is required.

**Note:** If you are a graduate of an out-of-state Nurse Practitioner program, request an official transcript be mailed directly from the program/registrar to the PA State Board of Nursing. An official transcript must:

- Be sent directly to the Board from the program/school which awarded the degree or certificate.
- Non-official transcripts, such as a **student copy or student submitted copy, are not acceptable.**
- Designate the degree or certificate awarded.
- Indicate the month, day and year the Nurse Practitioner program was completed.

**\*National Certification Organization**

**Specialty**

American Academy of Nurse Practitioners (AANP)

Adult Nurse Practitioner  
Adult-Gerontology Primary Care Nurse Practitioner  
Family Nurse Practitioner

American Association of Critical Care Nurses (AACN)

Adult Acute Nurse Practitioner  
Adult-Gerontology Nurse Practitioner

American Nurses Credentialing Center (ANCC)

Acute Nurse Practitioner  
Adult Nurse Practitioner  
Adult-Gerontology Acute Care Nurse Practitioner  
Adult-Gerontology Primary Care Nurse Practitioner  
Adult Psychiatric-Mental Health Nurse Practitioner  
Family Nurse Practitioner  
Gerontology  
Pediatric Primary Care Nurse Practitioner  
Psychiatric-Mental Health Nurse Practitioner

National Certification Corporation (NCC)

Women's Health Care Nurse Practitioner  
Neonatal Nurse Practitioner

Oncology Nursing Certification Corporation (ONCC)

Advanced Oncology Nurse Practitioner

Pediatric Nursing Certification Board (PNCB)

Pediatric Acute Care Nurse Practitioner  
Pediatric Primary Care Nurse Practitioner

**FORM 1: APPLICATION FOR CERTIFICATION AS A REGISTERED NURSE PRACTITIONER (CRNP)**

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

\_\_\_\_\_  
List any other names you have used

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

Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

(\_\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_  
Daytime Phone Number

**SECTION B: CRIMINAL/DISCIPLINARY HISTORY: ANSWER THE FOLLOWING QUESTIONS:**

		YES	NO
1.	Have you ever been convicted, found guilty, or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		

If you answered YES to question 1, attach a Criminal History Records Check (see General Instructions) and appropriate court documents with a detailed, signed and dated personal explanation.

		YES	NO
2.	Have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		
3.	Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		

If you answered YES to question(s) 2 and/or 3, attach a detailed, signed and dated personal explanation and contact the proper licensing authority where the action was taken and request that a certified copy of the order be sent directly to the PA Board.

Name: \_\_\_\_\_

SSN: \_\_\_\_\_

**SECTION C: NURSE PRACTITIONER EDUCATION:**

Type of Degree Awarded: Master's \_\_\_\_\_ Post-Master's \_\_\_\_\_ DNP \_\_\_\_\_ Other \_\_\_\_\_  
(Select One) (Specify)

Full Name of College or University: (No abbreviations)

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Name appearing on official transcript (if different): \_\_\_\_\_

Program Specialty: \_\_\_\_\_ Program Completion Date: \_\_\_\_\_  
(MM/DD/YYYY)

**SECTION D: NATIONAL CERTIFICATION:**

National Certification Organization: \_\_\_\_\_ National Certification ID Number \_\_\_\_\_

Specialty of National Certification Examination: (Select ONE specialty per application)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acute Care                    | <input type="checkbox"/> Adult                          | <input type="checkbox"/> Adult Acute Care                  |
| <input type="checkbox"/> Adult-Gerontology Acute Care  | <input type="checkbox"/> Adult-Gerontology Primary Care | <input type="checkbox"/> Adult Psychiatric-Mental Health   |
| <input type="checkbox"/> Advanced Oncology             | <input type="checkbox"/> Family                         | <input type="checkbox"/> Family/Individual Across Lifespan |
| <input type="checkbox"/> Gerontology                   | <input type="checkbox"/> Neonatal                       | <input type="checkbox"/> Pediatric Acute Care              |
| <input type="checkbox"/> Pediatric Primary Care        | <input type="checkbox"/> Psychiatric-Mental Health      | <input type="checkbox"/> Women's Health Care               |
| <input type="checkbox"/> Women's Health/Gender-Related |   |  |

**SECTION E: LICENSURE HISTORY:**

Are you recognized as a Nurse Practitioner (active or inactive status) by another state? **Yes\*** \_\_\_\_\_ **No** \_\_\_\_\_

\*If yes, list the state(s) and date(s): \_\_\_\_\_

**SECTION F: AFFIDAVIT: Read, sign and date.**

By submitting this information I verify that I am of good moral character and, if requested, I shall furnish evidence satisfactory to the Board of Nursing. To the best of my knowledge and belief, this application contains no misrepresentation, falsification, omission or concealment of material fact and the information given by me is true and complete. 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 the suspension, revocation or denial of my license, permit or certificate. 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. I have an ongoing responsibility to immediately report to the Board, in writing, any change(s) in information previously provided to the Board on my application. I understand it is my responsibility to know the legal requirements governing the practice of my profession and to remain knowledgeable regarding any changes in those requirements. I understand that if I do not successfully complete all requirements established by the program by the date indicated on my application, I must immediately notify the Board and I am not eligible for certification.

Applicant's Full Legal Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Must be original) (MM/DD/YYYY)

In order to comply with federal law, the State Board of Nursing is obligated to inform each applicant or licensee from whom it requests a Social Security number that disclosing such number is mandatory in order for this Board 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). In order to enforce domestic support orders, at the request of the Commonwealth's Department of Public Welfare (DPW), the licensing boards must provide to DPW information prescribed by DPW about the licensee, including the Social Security number. Additionally, disclosing the number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank. If this Board is required to make a report about one of its applicants or licensees to this Data Bank, it must report that individual's Social Security number.

**PENNSYLVANIA STATE BOARD OF NURSING**

**FORM 2 - VERIFICATION of NURSE PRACTITIONER PROGRAM**

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

**FORM 2 - TO BE COMPLETED BY THE NURSE PRACTITIONER PROGRAM DIRECTOR ONLY**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(MM/DD/YY)

Provide the last 4 numbers of the student's Social Security Number: XXX-XX-\_\_\_\_\_

Name of the College or University: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip Code)

Specialty (Population): \_\_\_\_\_

Date student completed the Nurse Practitioner program: \_\_\_\_\_ Awarded: \_\_\_\_\_  
(MM/DD/YY) MSN, DNP, POST-MASTER'S, OTHER

**To be Completed by Out-of-State Nurse Practitioner Program Directors Only:**

List the total number of clinical experience hours completed by this graduate: \_\_\_\_\_

Length of program: \_\_\_\_\_ Program Accreditation: CCNE \_\_\_\_\_ ACEN \_\_\_\_\_  
(Months)

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 or designee**  
(Name stamp is not acceptable)

[ SCHOOL SEAL ]

\_\_\_\_\_  
Print or type the name of Program Director or designee

\_\_\_\_\_  
Program Director or designee's Contact Phone Number

\_\_\_\_\_  
Date Signed

**DO NOT RETURN THIS FORM TO APPLICANT**

**MAIL DIRECTLY TO THE PENNSYLVANIA STATE BOARD OF NURSING IN AN OFFICIAL SCHOOL ENVELOPE**

**Mail Form To:**  
Pennsylvania State Board of Nursing  
CRNP Applications  
P.O. Box 2649  
Harrisburg, PA 17105-2649

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

**VALID FOR ONE (1) YEAR**

# FORM 3 - VERIFICATION OF NURSE PRACTITIONER LICENSURE

## Section A. Completed by Applicant only. Contact original licensing authority to confirm fee for verification.

<b>Name:</b> _____ Last                      First                      Middle                      Maiden Name	<b>Date of Birth:</b> _____ MM      DD      YYYY
<b>Current Address:</b> _____ Street                      City                      State                      Zip Code	
<b>Social Security Number:</b> _____ - _____ - _____	
<b>Current Licensure / Certification:</b> _____ State                      License Number	

## Section B. Completed by Original Licensing Authority only.

<b>This is to certify that</b> _____ Applicant's Name	
<b>was issued license/certification number</b> _____	<b>Specialty:</b> _____ (If Applicable)
<b>Date Issued:</b> _____ MM      DD      YYYY	<b>Current licensure/certification Status:</b> <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed
<b>Basis for Licensure:</b> <input type="checkbox"/> Endorsement <input type="checkbox"/> National Certification <input type="checkbox"/> Waiver <input type="checkbox"/> Other: _____	
<b>Prescriptive Authority issued:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, date issued:</b> _____	
<b>Has this license ever been disciplined in any manner or are disciplinary charges pending?</b> Check one: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please send certified copies of Board actions)	
_____	
<b>Nurse Practitioner Program:</b> _____	
<b>Location:</b> (City, State/Province/Territory): _____	
<b>Program Completion Date:</b> _____	<b>Specialty (Population):</b> _____ (If Applicable)
<b>Approved by State/Province/Territory:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

Original Signature of Licensing Officer: \_\_\_\_\_

Title: \_\_\_\_\_

(SEAL)

Name of Licensing Authority: \_\_\_\_\_

Location: \_\_\_\_\_

Date: \_\_\_\_\_

**Mail Form To:**  
Pennsylvania State Board of Nursing  
P.O. Box 2649, CRNP Applications  
Harrisburg, PA 17105-2649

**Physical Address:**  
Pennsylvania State Board of Nursing  
2601 North Third Street  
Harrisburg, PA 17110

**VALID FOR ONE (1) YEAR**