NORTH CAROLINA BOARD OF NURSING
APPLICATION FOR RECOGNITION AS A CLINICAL NURSE SPECIALIST

NOTICE: THIS IS NOT THE CERTIFIED REGISTERED NURSE ANESTHETIST APPLICATION.

IMPORTANT INSTRUCTIONS

- PLEASE PRINT IN BLACK OR BLUE INK OR CAN BE TYPEWRITTEN.
- KEEP COPY OF FORM FOR YOUR RECORDS.
- ENCLOSE NON-REFUNDABLE PROCESSING FEE OF $25.00 (Check, Money Order or Credit Card) PAYABLE TO: NORTH CAROLINA BOARD OF NURSING.
- SEND FORM, PROCESSING FEE AND ADDITIONAL MATERIALS TO:
  NORTH CAROLINA BOARD OF NURSING
  PRACTICE COORDINATOR
  PO BOX 2129 - RALEIGH, NC 27602

NCBON OFFICE USE ONLY

___ Fee received
___ RN verified
___ National certification
___ Graduate degree
___ Letter from program director
___ School accredited

ALLOW 4-6 WEEKS TO PROCESS

Have additional questions? Please contact:
Paulette Hampton, Practice Coordinator, NCBON
919/782-3211 ext. 244
PAULETTE@ncbon.com

A. GENERAL INFORMATION

Full Name _____
(Last) (First) (Middle) (Maiden)

Mother's Maiden Name _____

SS# _____ Date of Birth _____

Primary State of Residence _____ License Issued by State/US Possession ____

RN Cert/License # _____ Expiration Date _____

Home Address:
Street _____

City _____ State _____ Zip Code _____

Telephone Number (Home) _____ (Work) _____

Email Address _____

Name of Employer _____

Address of Practice Setting _____

Type of Current Practice Setting: (If more than one setting, estimate percent of time spent in each setting.)

☐ Hospital ☐ Health Department Clinic(s)
☐ Nursing Home ☐ Industry
☐ Home Care ☐ Health Maintenance Organization
☐ Other (Specify) _____

B. GRADUATE NURSING EDUCATION

Name and Address of Academic Institution:

Name _____

City and State _____

Date of Graduation _____

Degree Granted _____ Program Clinical Nursing Specialty Area _____

APPLICATION MUST INCLUDE:

- **A COPY OF YOUR GRADUATE DEGREE**
- **LETTER FROM YOUR PROGRAM DIRECTOR (SENT TO THE NCBON DIRECTLY FROM SCHOOL) ATTESTING THAT YOU HAVE COMPLETED A GRADUATE PROGRAM REQUIRING A MINIMUM OF 500 HOURS OF CLINICAL EXPERIENCE IN A CLINICAL NURSING SPECIALTY (NOTARIZED WITH DIRECTOR'S ORIGINAL SIGNATURE) - *(FORM AT END OF APPLICATION).***

  NOTE: For a dual track graduate program, if less than 500 hours per track, documentation of any crossover which would justify less than an additional 500 hours for the second track is required.

C. CERTIFICATION*

Credentialing Body _____

Address _____

Certification Title _____ Certification Specialty Area _____

Certification Number _____ Expiration Date _____

(CURRENT NATIONAL CERTIFICATION CERTIFICATE WITH CERTIFICATION NUMBER AND EXPIRATION DATE. MUST BE SENT TO THE NCBON DIRECTLY FROM THE CREDENTIALING BODY). COPIES WILL NOT BE ACCEPTED.

***PLEASE NOTE: Certification must be from a credentialing body requiring:**

1) **an unencumbered registered nurse license; and,**
2) **certification as a clinical nurse specialist is limited to a MASTERS, POST-MASTER'S CERTIFICATE or DOCTORAL prepared applicant effective January 1, 2010.**

(If your certification exam allows an individual with a Bachelor's to sit for the exam, the NCBON will be unable to accept that certification.)

I hereby certify that the information provided in this application is accurate and complete.

Signature _____
(Original signature)

Date _____

REMINDER:
Please submit all of the following:

⇒ Completed application form with original signature
⇒ Processing fee of $25 for processing of application
⇒ Copy of graduate degree
⇒ Letter from program director (notarized with director's original signature – sent directly to NCBON from school)
⇒ Current national certification certificate with certification number and expiration date must be sent to the NCBON directly from the credentialing body. Copies will not be accepted.

Please see next page for credit card payment.

CREDIT CARD PAYMENT

Credit Card Type ☐ MasterCard ☐ Visa

Expiration Date Month ☐☐ Year ☐☐

Cardholder Name (as it appears on Credit Card) _____

Cardholder Billing Address _____
(Street/PO Box)

City_____ **State**_____ **Zip Code**_____

Total Amount $_____

Cardholder Signature_____

Credit Card Number																	CVV#			

Cardholder Signature cannot be accepted via fax.

P.O. BOX 2129
Raleigh, NC 27602
(919) 782-3211
FAX (919) 781-9461
Nurse Aide II Registry (919) 782-7499
www.ncbon.com

FORM LETTER FOR
CLINICAL NURSE SPECIALIST PROGRAM DIRECTOR

LETTER IS TO BE NOTRAIZED WITH DIRECTOR'S ORIGINAL SIGNATURE

PLEASE SEND TO: NORTH CAROLINA BOARD OF NURSING
ATTN: PRACTICE COORDINATOR
PO BOX 2129
RALEIGH, NC 27062

Date: _____

Dear North Carolina Board of Nursing:

This letter is to verify that _____ has completed a graduate program on _____ at
(name of CNS applicant) *(date)*

_____ which requires a minimum of 500 hours of clinical experience in the clinical
(name of graduate school)

nursing specialty of _____.
(clinical nursing specialty)

_____
Program Director's original signature

North Carolina
_____ County

I, _____, a Notary Public for said County and State, do hereby certify that _____ personally appeared before me this day and acknowledge the due execution of the foregoing instrument.

Witness my hand and official seal, this the _____ day of _____, 20 ___.

(Official Seal)

_____
Notary Public

My commission expires _____, 20___