GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS

-----O-----

DEPARTMENT OF HEALTH

Virgin Islands Board of Nurse Licensure

P.O. Box 304247

Tel: (340) 776-7397 St. Thomas, Virgin Islands 00803 Fax: (340) 777-4003

Dear Advance Practice Applicant,

In response to your request for an endorsement application to practice as an Advanced Practice Registered Nurse (APRN) - Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Nurse Midwife, Clinical Nurse Specialist, or Nurse Practitioner, the Virgin Islands Board of Nurse Licensure (VIBNL), request the following documents for review:

Applicants recently certified by a National Certifying Organization and holding a current unencumbered Registered Nurse license for the territory of the US Virgin Islands are required to complete numbers 1-11.

Please complete and submit the following:

1) A notarized APRN Endorsement Application.

2) Proof of Social Security Card.

3) Two “2X2" passport type quality photographs. Please print and sign your name on the back.

4) A current unencumbered license as a Registered Nurse in the United States Virgin Islands that is not expiring within 90 days from the date of your application.

5) A legible copy of your diploma or official transcript from a VIBNL approved undergraduate nursing program.

6) A legible copy of your certificate or diploma and official transcript from a VIBNL approved advanced practice nursing specialty program.

7) A current unencumbered specialty certificate or license to practice in the U.S., U.K.C.C., or designated islands in the Caribbean that is not expiring within 90 days from the date of submission of your application.

8) Official Verification of a current certification in one of the following advanced practice categories: ACNM, AANA, NAACOG, ANCC, UKCC, ANA, etc. from the national organization which issued the certification.

9) An affidavit with official documentation indicating any name change, if applicable (marriage license, divorce decree, etc).

10) A complete copy of a Collaborative Agreement with a physician or the institution where you will be employed within the United States Virgin Islands.

11) Preceptorship agreement with a Physician or Advance Practice Registered Nurse in the area of your specialty.

Applicants currently practicing in an advanced practice role, in addition to items 1-11, please complete and submit the following:

12) Official Verification of an unencumbered nursing license for both your RN & APRN scope of practice that will not expire 90 days from the date on your application.

13) Documentation of the places and dates of employment in which you functioned in your advanced practice specialty role within the past five (5) years.

14) Three (3) letters of recommendation attesting to currency of your specialty practice, (within the past five (5) years). Letters should include clear contact information, signature, and must be dated within three (3) months of the application.

15) Registration Fee: 150.00

    Fees are payable by money order, certified bank check, or credit/debit card. Personal checks will not be accepted. ***Note:*** *Only in-office transactions can be made with credit and debit cards. Make certified checks and money orders payable to:* ***Virgin Islands Board of Nurse License (VIBNL), P.O. Box 304247, St. Thomas, VI 00803***

    Note: Please use the following address when forwarding overnight parcels to the VIBNL.

    - FEDEX/UPS parcels = #3 Kongens Gade, Old Justice Complex, St Thomas, USVI 00802.
    - US Postal Service = 5051 Kongens Gade Suite 1, St Thomas, USVI 00802-6487.

FOREIGN TRAINED APPLICANTS:

For Foreign Graduate Nurses currently practicing in an advanced practice role, in addition to items 1-15, please submit the following:

1. Proof of having passed NCLEX-RN/SBTPE
2. Official Transcripts from the nurse specialty program, in English.
3. Official CGFNS Certificate/Report

PRESCRIPTIVE AUTHORITY:

In order for Prescriptive Authority to be designated on your USVI APRN license you must provide evidence of **ONE** of the following to the Board:

1. Documentation of current Prescriptive Authority from another state
2. Documentation of completion of an approved pharmacology course (minimum 30 contact hours) within the preceding two years
3. Documentation of a pharmacology course (minimum 30 contact hours) within your APRN educational program.
4. If applicable, documentation of a current DEA number

PLEASE ALLOW NINETY (90) BUSINESS DAYS AFTER VIBNL RECEIPT OF ALL REQUIRED DOCUMENTS FOR THE PROCESS OF YOUR APPLICATION TO BE COMPLETED.

Please Note:

Information on your application concerning disciplinary actions against your license/s must be completed and signed before a notary public. If you have ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a nurse, or as another healthcare professional, please include the supporting documents within your endorsement package.

Self-disclosure of all misdemeanors, felonies, plea agreements (even if adjudication was withheld), any substance use disorder in the last five (5) years, and any actions taken or initiated against a professional or occupational license, registration, or certification is required. Failure to do so may result in a disciplinary action by the VIBNL.

Office Hours: Business office hours of the VIBNL are Monday-Friday, 8:30 am - 4:00 pm. Please notify the VIBNL in writing if you intend to pick up your Licensure Registration card. Picture identification will be required to pick up licenses.

Communication: Should you have questions, need clarification, or require directions to the office of the VIBNL, please do not hesitate to contact the Board staff. We are committed to keeping you informed. Our numbers are: Phone: (340)776-7397 Fax: (340)777-4003.

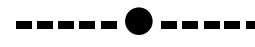
Thank you for your interest in nursing in the US Virgin Islands.

Sincerely,
Virgin Islands Board of Nurse Licensure

Physical Address
5051 Kongens Gade Suite 1
Old Justice Complex
St. Thomas, USVI 00802-6487

Check One
CRNA ( ), CNM ( ), CM ( ), NM ( )
NP ( ), other ( )________________

GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS



DEPARTMENT OF HEALTH
Virgin Islands Board of Nurse Licensure

P.O. Box 304247
Tel: (340) 776-7397 St. Thomas, Virgin Islands 00803 Fax: (340) 777-4003

Endorsement Application for Advance Practice Registered Nurse (APRN)

1. Name in full ____
   (Print) Last First Middle Maiden

2. Mailing Address ______________________________________ Soc. Sec# _________________

3. Virgin Islands Address_______________________________________ Tel. # _______________

4. Forwarding Address ____

5. Email Address ____

6. DOB________________ Birth place _________________________Marital Status: S M D W

7. Are you a US citizen? _____________________ Give Visa Status _________________________

8. How would you rate your own general (physical and mental) health? ________________________

9. Do you have any disability that should be reported to this Board? ___________________________

10. Were you ever issued a license to practice nursing within the Territory of the United States Virgin Islands? Yes ( ) No ( )
    If yes, please provide VI license information: ____

EDUCATION HISTORY:

11. Nursing Undergraduate Program _______________________________ Grad. Date ___________
    Address of Nursing School ____
    Circle One: Dip., ASN, ADN, BSN

12. Advance Practice Nursing Program ______________________________ Grad. Date __________
    Address of Nursing School ____
    Masters Degree in ____Grad. Date ___________
    Certifying Organization ____

13. What year did you pass the Commission on Graduated of Foreign Nursing Schools (CGFNS) exam?
    ____

14. Did you pass the Canadian Nursing Association Testing Services (CNATS) exam in English?
    Yes ( ) No ( ) Date __________________

LICENSURE HISTORY:

15. State, or Territory where you passed the SBTPE/NCLEX – RN/NCLEX-PN exam? ____________
    Exam Date: ______________

16. State of original licensure _____________________ Lic. Status __________ Exp. Date ________

17. State(s) in which you are currently licensed:
    State ___________________ Lic# _______________ Eff. Date ___________ Exp. Date ________
    State ___________________ Lic# _______________ Eff. Date ___________ Exp. Date ________

18. State(s) in which you are currently APRN Certified:
    State ___________________ Lic# _______________ Eff. Date ___________ Exp. Date ________
    State ___________________ Lic# _______________ Eff. Date ___________ Exp. Date ________

19. Current DEA #__________________________ State ____________________ Exp. Date _______

20. Provide three (3) Letters of Recommendation attesting to currency of your specialty practice, within the past five (5) years. Letters should include clear contact information, signature, and dated within three months of the application.

21. Has there been any complaints or disciplinary action taken or pending against your professional nursing or occupational license, registration, or certification? Yes ( ) No ( )
    If Yes, List State (s) _________________________________, License# (s) ___________________,
    date(s) the action was taken ______________________, and a description of the action on the back of the National License Verification Form. Please attach supporting documents.
    You must disclose all misdemeanors, felonies, plea agreements (even if adjudication was withheld),any substance use disorder in the last five (5) years, and any actions taken or initiated against a professional or occupational license, registration, or certification is require.

22. Return the completed Collaborative Agreement, signed by a Physician licensed to practice in the United States Virgin Islands, to the VIBNL office prior to issuance of your license.

23. ***My signature on this application constitutes my express authorization for the Government of the US Virgin Islands, Department of Health, Board of Nurse Licensure and/or its agents to make an independent investigation of my background, references, character, past employment, education, credit history, criminal, or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained in the foregoing applications. I understand that this authorization is for the express purpose of determining that I am of good character pursuant to the Nurse Practice Act, codified in Title 27, Chapter 1, Section 91, et seq., of the Virgin Islands Code. YES ___ NO ___***

Notary Public Seal ______________________________
Signature

____
Date

____
(Applicant's Signature) Date

Office use only:
______________ ______________
Initial date

Rev. 10/2013, 08/201, 11/2013

Virgin Islands Board of Nurse Licensure of The Virgin Islands of the United States of America

Return Address:
P.O. Box 304247
St. Thomas, VI 00803

NATIONAL LICENSURE VERIFICATION FORM

APPLICANT

PART 1: To be completed by the applicant and forwarded to appropriate licensing board IN THE U.S.

Name (Last, First, Middle/Maiden)	Previous Name (s)
Current Street Address	City, State, Zip
Date of Birth (mo/day/yr) / Social Security Number	Current License Number / Type ☐ RN ☐ LP/VN / State
Name as it appears on original license (Last, First, Middle/Maiden)	Original State of Licensure
Original License Number / Type ☐ RN ☐ LP/VN	Date Issued
Nursing Education Program Completed	Location (city, state) / Graduation Date

LIST ALL OTHER STATES OF LICENSURE
State:__________ License Number: __________ Date Issued: __________
State:__________ License Number: __________ Date Issued: __________
State:__________ License Number: __________ Date Issued: __________
State:__________ License Number: __________ Date Issued: __________

I hereby authorize all identified Boards of Nursing to release my licensure data to the __________ Board of Nursing.
State
Signature__________
Date__________

LICENSING BOARD ONLY

PART 11: To be completed by licensing board and forwarded to Board of Nursing listed at the top of this form.

This is to certify that the above named individual was issued license number __________ Date Issued__________
to practice ☐ registered nursing.
☐ practical/vocational nursing

Licensed by: ☐ Examination ☐ Endorsement ☐ Waiver

Current Licensure Status: ☐ Active ☐ Inactive ☐ Lapsed
Expiration Date: __________

Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)? ☐ Yes ☐ No
Disciplinary Action Pending? ☐ Yes ☐ No Explain yes responses on the reverse side.

Nursing Education Program Completed	Approved by State? ☐ Yes ☐ No	Graduated From ☐ H.S. ☐ H.S. Equivalency ☐ Completion of 10th Grade
Location (city/state)	Graduataed Date	

	STATE BOARD TEST POOL EXAMINATION Registered Nurse					LP/VN	NCLEX RN	NCLEX LP/VN
	Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children			
Score								
Series/Form #								

Score
☐ State/Provincial Constructed Exam __________
☐ CNATS Exam __________
☐ Other (please explain) __________

Number of times applicant wrote exam.: __________ Dates:__________
Exam in English? ☐ Yes ☐ No

Signature__________
Title __________
State __________ Date__________

SEAL

LICENSE VERIFICATION (CON'T)

Description of previous Disciplinary Action (Please attach any charges/Accusations and decisions/determinations.)

REASON

___

___

PENALTY AND DATE

___

___

Reinstated: N________________ Y________________ When __________________________

___

DESCRIBE DISCIPLINARY ACTION.

___

___

ATTACH PERTINENT DOCUMENTS IF APPLICABLE

___

___

STATE BOARDS OF NURSING:

State	Phone		State	Phone
Alabama	(205) 242-4060		Missouri	(314) 751-0681
Alaska	(907) 465-2544		Montana	(406) 444-2071
American Samoa	(684) 633-1222		Nebraska	(402) 471-2115
Arizona	(602) 255-5092		Nevada	(702) 739-1575
Arkansas	(501) 686-2700		New Hampshire	(603) 271-2323
California	(916) 322-3350		New Jersey	(201) 648-2493
Colorado	(303) 894-2432		New Mexico	(505) 841-8340
Connecticut	(203) 566-1132		New York	(518) 474-3817
Delaware	(302) 739-4522		North Carolina	(919) 782-3211
District of Columbia	(202) 727-7446		North Dakota	(701) 328-2974
Florida	(904) 488-5952		North Mariana Islands	(0-11-670) 234-8950
Georgia	(404) 656-7084		Ohio	(614) 466-3947
Guam	(671) 734-2950		Oklahoma	(405) 525-2076
Hawaii	(808) 548-3086		Oregon	(503) 731-4745
Idaho	(208) 334-3110		Pennsylvania	(717) 783-7144
Illinois	(217) 785-8556		Rhode Island	(401) 277-2827
Indiana	(317) 233-4414		South Carolina	(803) 731-1648
Iowa	(515) 281-6488		South Dakota	(605) 367-6362
Kansas	(913) 296-4929		Tennessee	(615) 367-5940
Kentucky	(502) 329-7000		Texas	(512) 835-4880
Louisiana	(504) 568-5464		Utah	(801) 530-6673
Maine	(207) 624-5275		Vermont	(802) 828-2396
Maryland	(410) 585-1900		Virgin Islands	(340) 776-7397
Massachusetts	(617) 727-9967		Virginia	(804) 662-9909
Michigan	(517) 373-3877		West Virginia	(304) 348-3596
Minnesota	(612) 642-0571		Wisconsin	(608) 266-0070
Mississippi	(601) 359-6180		Wyoming	(307) 777-7601

Return Address:
P.O. Box 304247
St. Thomas, VI 00803

Virgin Islands Board of Nurse Licensure of The Virgin Islands of the United States of America

NATIONAL CERTIFICATION VERIFICATION FORM

APPLICANT

PART 1: To be completed by the applicant and forwarded to Certifying Specialty Board ACNM, AANA, NAACOG, NCC, UKCC, ANA, etc.

Name (Last, First, Middle/Maiden)	Previous Name (s)
Current Street Address	City, State, Zip
Date of Birth (mo/day/yr) / Social Security Number	Certificate Program Completed / Grad. Date
Name as it appears on original license (Last, First, Middle/Maiden)	Location
Original State of License / Current State of License	National Certification Issued by:
Nursing Education Program Completed / Graduate date	

LIST ALL OTHER STATES OF CURRENT LICENSURE

State:______ License Number: ______ Date Issued: ______
State:______ License Number: ______ Date Issued: ______
State:______ License Number: ______ Date Issued: ______
State:______ License Number: ______ Date Issued: ______

I hereby authorize the Certifying Organization to release information regarding my certification.

Signature______

Date______

CERTIFYING ORGANIZATION ONLY

PART 11: To be completed by licensing board and forwarded to Board of Nursing listed at the top of this form.

This is to certify that the above named individual was issued license number ______ Date Issued______
to practice ☐ registered nursing. Certificate number ______ Date Issused______

Certified by: ☐ Examination ☐ Endorsement ☐ Waiver

Current Certification Status ☐ Active ☐ Inactive ☐ Lapsed

R.N. Licensure by: ______

R.N. Licensure Status:______ Expiration Date: ______

Has Certificate been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)? ☐ Yes ☐ No

Disciplinary Action Pending? ☐ Yes ☐ No Explain yes responses on the reverse side.

Nursing Education Program Completed

Approved by State? ☐ Yes ☐ No

Foreign Certificate Program CGFNS ☐ Location ______

Location (city/state)

Graduation Date

US Certificate Program ☐ Location ______ Grad/ date ______

STATE BOARD TEST POOL EXAMINATION

	Registered Nurse					NCLEX RN
	Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children	
Score						
Series/Form #						

Score

☐ State/Provincial Constructed Exam ______
☐ CNATS Exam ______
☐ Other (please explain) ______

Number of times applicant wrote exam.: ______ Dates: ______

Exam in English? ☐ Yes ☐ No

Signature______

Title ______

State ______ Date ______

SEAL

LICENSE VERIFICATION (CON'T)

Description of previous Disciplinary Action (Please attach any charges/Accusations and decisions/determinations.)

REASON

____

____

PENALTY AND DATE

____

____

Reinstated: N______________ Y______________ When______________

____

DESCRIBE DISCIPLINARY ACTION.

____

____

ATTACH PERTINENT DOCUMENTS IF APPLICABLE

____

STATE BOARDS OF NURSING:

Alabama	(205) 242-4060	Missouri	(314) 751-0681
Alaska	(907) 465-2544	Montana	(406) 444-2071
American Samoa	(684) 633-1222	Nebraska	(402) 471-2115
Arizona	(602) 255-5092	Nevada	(702) 739-1575
Arkansas	(501) 686-2700	New Hampshire	(603) 271-2323
California	(916) 322-3350	New Jersey	(201) 648-2493
Colorado	(303) 894-2432	New Mexico	(505) 841-8340
Connecticut	(203) 566-1132	New York	(518) 474-3817
Delaware	(302) 739-4522	North Carolina	(919) 782-3211
District of Columbia	(202) 727-7446	North Dakota	(701) 328-2974
Florida	(904) 488-5952	North Mariana Islands	(0-11-670) 234-8950
Georgia	(404) 656-7084	Ohio	(614) 466-3947
Guam	(671) 734-2950	Oklahoma	(405) 525-2076
Hawaii	(808) 548-3086	Oregon	(503) 731-4745
Idaho	(208) 334-3110	Pennsylvania	(717) 783-7144
Illinois	(217) 785-8556	Rhode Island	(401) 277-2827
Indiana	(317) 233-4414	South Carolina	(803) 731-1648
Iowa	(515) 281-6488	South Dakota	(605) 367-6362
Kansas	(913) 296-4929	Tennessee	(615) 367-5940
Kentucky	(502) 329-7000	Texas	(512) 835-4880
Louisiana	(504) 568-5464	Utah	(801) 530-6673
Maine	(207) 624-5275	Vermont	(802) 828-2396
Maryland	(410) 585-1900	Virgin Islands	(340) 776-7397
Massachusetts	(617) 727-9967	Virginia	(804) 662-9909
Michigan	(517) 373-3877	West Virginia	(304) 348-3596
Minnesota	(612) 642-0571	Wisconsin	(608) 266-0070
Mississippi	(601) 359-6180	Wyoming	(307) 777-7601

GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS
-----O-----
DEPARTMENT OF HEALTH
Virgin Islands Board of Nurse Licensure
P.O. Box 304247
Tel: (340) 776-7397 St. Thomas, Virgin Islands 00803 Fax: (340) 777-4003

AGREEMENT OF COLLABORATIVE RELATIONSHIP

Between

____, MD

________________________________, MSN, APRN

This Agreement of Collaborative Relationship has been made and is now duly written between ________________________________, MD and _____________________________, APRN as of this ______________ day of _________, __________. Said agreement which is being submitted as a required of the Virgin Islands Board of Nurse Licensure (VIBNL), shall show the intent for the following mutual collaborative responsibilities between the Advanced Practice Registered Nurse (APRN) and the Physician.

1. The Physician agrees to be available to the APRN for consultation collaboration and referral as necessary.
2. The APRN agrees to practice within the Scope of Practice as defined in the Rules and Regulations established by the Virgin Islands Board of Nurse Licensure.
3. Both parties agree to maintain high ethical and professional standards.

It is understood that any changes in this Agreement must be submitted to the VIBNL within 30 days of the change.

Respectfully Submitted,

______________________________	______________________________
Print Name of Physician	Print Name of APRN
______________________________	______________________________
Signature of Physician	Signature of APRN
______________________________	______________________________
Witness	Date

GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS

-----O-----

DEPARTMENT OF HEALTH

Virgin Islands Board of Nurse Licensure

P.O. Box 304247

Tel: (340) 776-7397 St. Thomas, Virgin Islands 00803 Fax: (340) 777-4003

TO: RNs, APRNs, & LPNs

FROM: Executive Director

RE: INITIAL LICENSURE/RENEWAL INFORMATION

By signing this form I _________________________________ license #_________________

Please read and initial the item/s that applies to your nursing scope of practice.

1. Understand that my United States Virgin Islands Midwifery Certification authorizes practice only in this territory's hospitals, clinics, approved health settings, and physician's offices. ____
2. Understand that as an Advance Practice Registered Nurse (APRN), I must complete the Collaborative Agreement form provided by the Board. Practice solely as an APRN in the specialty for which I am certified in and with the healthcare organization and/or physician on this agreement. ____
3. Understand that I must not violate the Scope of Practice or Nurses Code of Ethics as an LPN/RN/APRN in the United States Virgin Islands. _____
4. Understand that I must notify the Virgin Islands Board of Nurse Licensure (VIBNL) of any change in my mailing address. _____
5. Understand that I must complete two (2) of three (3) competencies in the previous biennium in order to renew my nursing license or specialty certificate. _____
6. Understand that my employer may contact the VIBNL to verify my license. ______
7. Information on your application concerning disciplinary actions against your license/s must be completed and signed before a notary public. If you have ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a nurse, or as another healthcare professional, please include the supporting documents within your application package. _______

____________________________	______________	___________________________
Signature	Date	Witness

Comments:

Cc: Board File

Rev. 10/05, 11/13

Bill No. 14-0094 Title 27-Act 4666 VI Code

Subchapter IV, Nursing

§ 91. Definitions

a) Description of the practice of nursing – the practice of nursing as performed by a Registered Nurse" is a process in which substantial knowledge derived from biological, physical, behavioral science is applied to the assessment, planning, intervention, and evaluation of person/s who are experiencing changes in the normal life processes; or who require assistance in the maintenance and promotion of health, and in the management of illness or infirmity; or in the achievement of dignified death. The nursing process is executed directly or indirectly through acts of supervision or teaching of others. It includes the administration of medication and treatment as established by standardized protocols, or prescribed by a licensed physician or dentist. The nurse may independently initiate emergency action.

The Registered Nurse, who is credentialed in a special area in nursing practice, may perform such additional acts as are authorized by the Virgin Islands Board of Nurse Licensure (VIBNL).

b) Description of the practice of nurse specialist – the practice of a nurse specialist means the performance of advanced or specialized nursing acts which require post basic registered nurse education and experience for which the specialist has been credentialed by a certifying body which is recognized by the board.

c) Description of licensed practical nurse – the practice of nursing by a licensed practical nurse means the basic application of the nursing process under the direction and supervision of a registered nurse, licensed physician, and/or licensed dentist to persons who are experiencing changes in the normal life process or who require assistance in the maintenance and promotion of health and in the management of illness, injury or infirmity, or in the achievement of dignified death. The licensed practical nurse executes such acts as the administration of medication and treatment as established by standardized protocol, or prescribed by a licensed physician or dentist. In addition, the licensed practical nurse may initiate emergency action if specifically prepared and authorized.