

**APPLICATION FOR APPOINTMENT
BOARD OF ADVANCED PRACTICE REGISTERED NURSES
(CLINICAL NURSE SPECIALIST MEMBER)**

PLEASE PRINT OR TYPE

Name:

First _____ Middle _____ Last _____ Credentials (ie, CNS, etc., if applicable) _____

Mailing Address:

Street/Box/RR _____

City _____ State _____ Zip _____

Business Telephone _____ Cell/Pager _____ Residence Telephone _____

Email Address _____ FAX Number () _____

Are you available to meet, usually in Lincoln, on a monthly basis, if necessary or required for Board Meetings? Yes No

Please indicate how you became aware of this vacancy on this Board.

Professional Association DHHS Web Page Newspaper Other (please explain)

ELIGIBILITY REQUIREMENTS

Do you hold a current Nebraska license to practice as an advanced practice registered nurse-clinical nurse specialist (APRN-CNS)?
Yes No (Statutes require the APRN-CNS member of the board shall have held and maintained an active APRN-CNS license for a period of five years just preceding appointment and shall maintain such license while serving as a board member.)

Have you been actively engaged in practice as an APRN-CNS for the five (5) years just preceding this application? Yes No
(Statutes require the APRN-CNS member of the board shall have been actively engaged in practice as a APRN-CNS for a period of five years just preceding appointment and shall maintain such practice while serving as a board member. Active practice means devoting a substantial portion of time to rendering professional services.)

Provide the number of years you have been engaged in practice as an APRN-CNS _____

Have you been a resident of the State of Nebraska for at least one (1) year? Yes No (Statutes require every member of the board shall have been a resident of Nebraska for one year and shall remain a resident of Nebraska while serving as a board member.)

EDUCATION

School _____ Location _____ Degree/Specialty _____ Completed Date _____

PLEASE COMPLETE REVERSE SIDE

**DETAILED DESCRIPTION OF WORK EXPERIENCE AS A CLINICAL NURSE SPECIALIST
WITHIN THE LAST FIVE YEARS IN NEBRASKA**

Type of Experience	Name & Location	From	To	Average Number of Hours Per Week

ADDITIONAL INFORMATION

Describe your interest in advanced practice registered nursing and why you wish to serve on this Board.

Are you aware of any reason why your appointment might be considered a conflict of interest as defined in Title 172 NAC 3, Regulations Establishing Definitions of Conflicts of Interest for Members of the Boards of Examiners in the Health Professions?
Yes No If yes, explain.

Have you ever had your statutory ability to practice or clinical privileges suspended or revoked? Yes No

Are you currently under investigation? Yes No

I swear and affirm that all information I have provided on this application is true and complete to the best of my knowledge.

Signature

Date

**Return completed Application to: Monica Gissler, State Board of Health,
Nebraska DHHS, Division of Public Health, Licensure Unit, 301 Centennial Mall South,
P.O. Box 95026, Lincoln, NE 68509-5026
402/471-6515; FAX 402/471-0383; Monica.gissler@nebraska.gov**