



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF NURSING
615-532-5166 or 1-800-778-4123

FEES ARE NON REFUNDABLE

**REGISTERED NURSE FIRST ASSISTANT
INSTRUCTIONS/APPLICATION**

Please allow 4-6 weeks processing time for a license/certificate. If additional information is required you will be notified. It is not necessary to call the Board to check on the status of your application; go to www.tn.gov/health, click on verification.

To apply for Registered Nurse First Assistant (RNFA) Certificate, submit the following:

1. Application. Complete all sections.
2. Affix one (1) recent professional passport type (2½" x 2½") photograph.
 - a) Vending machines, snapshots, ID photographs, or paper photographs are **NOT** acceptable.
 - b) Straight on pose including head and shoulders.
 - c) Full legal signature and date on front of photograph - signature must not conceal face, no "nicknames".
 - d) Date the photograph was taken must be no more than six months prior to date of application.
3. Sign affidavit on page 2 in the presence of a Notary Public.
4. Request an official transcript or copy of a certificate of completion from a registered nurse first assistant education program that meets the education standard of the Association of PeriOperative Registered Nurses forwarded directly from the school to the Board of Nursing.
5. Declaration of Citizenship (with required documentation). Sign affidavit in the presence of a Notary Public.
6. RNFA CERTIFICATE FEE*
Attach the correct fee in U.S. currency. Check or money order must be made payable to the Tennessee Board of Nursing.
 - a. RNFA Certificate Fee \$100.00
 - b. State Regulatory Fee 10.00\$110.00

Please allow 4-6 weeks for processing. Please contact the Board if you have not received a notification after six (6) weeks from the date your check has been redeemed by your financial institution.

If you change your address, it is your responsibility to notify this office or change address online at www.tn.gov/health.
If you change your name, you must submit a copy of the legal document that changed your name. Fax to (615) 741-7899.

PASSPORT TYPE
PHOTOGRAPH
NOT TO EXCEED
2½" x 2½"

AFFIX PHOTOGRAPH HERE
SIGNED AND DATED
ON THE FRONT BY

Tennessee Board of Nursing
665 Mainstream Drive
Nashville, TN 37243



1707 001-\$100.00
006-\$ 10.00

**FEES ARE NOT
REFUNDABLE**

APPLICATION FOR CERTIFICATE

REGISTERED NURSE FIRST ASSISTANT

PLEASE REFER TO INSTRUCTION SHEET WHEN COMPLETING THE APPLICATION; PRINT OR TYPE.
ALL QUESTIONS MUST BE COMPLETED.

PART 1 PERSONAL INFORMATION

1. Name _____
Last First Middle Maiden
2. List any other names by which you have been known _____
Last First Middle
3. Social Security Number _____ Telephone Number (____) (____)
Home Office
Your social security number may be used to verify your identify and for any other purpose allowed by state of federal law.
4. U.S. Citizenship Yes No All applicants **must** complete the attached Declaration of Citizenship.
5. Date of Birth _____ Gender Female Male
6. Ethnic Group White Black Native American Indian Asian Hispanic Other, Specify _____
7. Mailing Address _____
Street/PO Box City/State/Zip
Physical Address _____
(required if Mailing Address is a PO Box) Street City/State/Zip
8. Do you wish to receive notification, including renewal notification, from the Department of Health via email? Yes No
Email Address _____
9. Tennessee RN License Number _____
If practicing in Tennessee on the multistate privilege, list state and license number _____

PART 2 REGISTERED NURSE FIRST ASSISTANT INFORMATION

10. Registered Nurse First Assistant Education

Name of First Assistant Educational Program and Affiliating School of Nursing _____
Location _____
City _____ State _____
Completion Date _____
School of Nursing Accrediting Agency _____

11. Disciplinary Action

11.1 Have you ever had a nursing license (LPN, RN, RNFA or APN) or certification or any other professional license, certificate, privilege or registration disciplined (revoked, suspended, placed on probation or reprimanded) or voluntarily surrendered in any state or jurisdiction? Yes No

11.2 If yes, please identify the profession and state where the action was originally taken _____
State _____

12. Are you currently in good physical and mental health? (Include any physical or mental limitations) Yes No
If no, please explain _____

13. Conviction of a Crime

13.1 Have you ever been convicted or pled guilty to a misdemeanor or felony other than a minor traffic violation? Yes No
If yes, please specify date of conviction and submit a certified copy of the warrant and judgment or conviction papers and evidence of completion of fines, restitution, probation, and a letter of explanation that describes the circumstances that resulted in arrest.

13.2 If yes, specify date and type of conviction.
Date _____ Type of Conviction _____
Month/Day/Year

14. Please indicate your major practice area in nursing: Check Only One

- | | |
|--|---|
| <input type="checkbox"/> Community/Public Health (1) | <input type="checkbox"/> Emergency Service (9) |
| <input type="checkbox"/> General Practice (2) | <input type="checkbox"/> Case Management (11) |
| <input type="checkbox"/> Geriatric (3) | <input type="checkbox"/> Primary Care (12) |
| <input type="checkbox"/> Obstetric/Gynecologic (4) | <input type="checkbox"/> Education (13) |
| <input type="checkbox"/> Medical/Surgical (5) | <input type="checkbox"/> Administrative/Management (14) |
| <input type="checkbox"/> Pediatric (6) | <input type="checkbox"/> Perioperative (15) |
| <input type="checkbox"/> Psychiatric/Mental Health (7) | <input type="checkbox"/> Other, Please Specify (10) _____ |
| <input type="checkbox"/> Critical/Intensive Care (8) | |

22. Please indicate your principal setting of Employment: Check Only One

- | | |
|---|---|
| <input type="checkbox"/> Hospital/Medical Center (1) | <input type="checkbox"/> Industrial/Occupational (8) |
| <input type="checkbox"/> Ambulatory/Outpatient Clinic, Free Standing Surgery Center (2) | <input type="checkbox"/> Community/Public Health (9) |
| <input type="checkbox"/> Office (Physician or Dentist) (3) | <input type="checkbox"/> Hospice (13) |
| <input type="checkbox"/> Nursing Home (4) | <input type="checkbox"/> School Nurse (11) |
| <input type="checkbox"/> Home Health (5) | <input type="checkbox"/> School of Nursing/College/ University (12) |
| <input type="checkbox"/> Private Duty (6) | <input type="checkbox"/> Assisted Living/Home for the Aged (15) |
| <input type="checkbox"/> Insurance (7) | <input type="checkbox"/> Other, Please specify (10) _____ |

23. Please indicate your current type of nursing position Check Only One

- | | |
|--|---|
| <input type="checkbox"/> Administrator (1) | <input type="checkbox"/> Nurse Practitioner (Certificate of Fitness to prescribe) (12) |
| <input type="checkbox"/> Consultant (2) | <input type="checkbox"/> Clinical Specialist (8) |
| <input type="checkbox"/> Supervisor or Assistant (3) | <input type="checkbox"/> Clinical Specialist (Certificate of Fitness to prescribe) (13) |
| <input type="checkbox"/> Instructor or Educator (4) | <input type="checkbox"/> Nurse Midwife (Certified) (10) |
| <input type="checkbox"/> Head Nurse or Assistant (5) | <input type="checkbox"/> Nurse Midwife (Certificate of Fitness to prescribe) (14) |
| <input type="checkbox"/> Staff or General Duty (6) | <input type="checkbox"/> Quality Assurance (15) |
| <input type="checkbox"/> Nurse Anesthetist (17) | <input type="checkbox"/> Case Manager (16) |
| <input type="checkbox"/> Nurse Anesthetist (Certified) (9) | <input type="checkbox"/> Other, please specify (11) _____ |
| <input type="checkbox"/> = Nurse Practitioner (7) | |

24. Please indicate your highest degree in nursing: **Check Only One**
- | | |
|--|---|
| <input type="checkbox"/> Diploma (1) | <input type="checkbox"/> Master's in Nursing (4) |
| <input type="checkbox"/> Associate degree in Nursing (2) | <input type="checkbox"/> Doctorate in Nursing (5) |
| <input type="checkbox"/> Bachelor's in Nursing (3) | |
25. Please indicate your highest degree in another field, if applicable: **Check Only One**
- | | |
|---|---|
| <input type="checkbox"/> No Other Degree Held (6) | <input type="checkbox"/> Master's (9) |
| <input type="checkbox"/> Associate (7) | <input type="checkbox"/> Doctorate (10) |
| <input type="checkbox"/> Bachelor's (8) | |

AFFIDAVIT

State of _____

County of _____

_____ personally appearing before me, being duly sworn says that he/she is the person
(Name of Applicant)

referred to in the foregoing application for a certificate as a Registered Nurse First Assistant in the State of Tennessee that the statements therein contained are true and that he/she has read and understands this affidavit. **I understand that if the processing is not completed, the application becomes null and void one year from date received.** I also understand that falsification of an application is grounds for denial of licensure or discipline against a license. I hereby authorize release, use and disclosure of otherwise HIPPA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

Legal Signature of Applicant _____

Sworn to before me this _____ day of _____, 20 _____

Notary Public _____

SEAL

Commission Expires _____

FOR OFFICE USE ONLY

NAME _____

LICENSE NO. _____ DATE ISSUED _____



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a (n) _____
Healthcare Profession (Please Print) License number if applicable

Declaration of Citizenship must be completed, page 2 notarized by a notary, and the required documentation attached.

Please Print Legibly

1. Name: _____
Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____) ____ - ____ Office: (____) ____ - ____ Fax: (____) ____ - ____
4. I am a United States Citizen: ___Yes ___No
5. I am a foreign national not physically present in the United States ___Yes ___No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** submit **one** of the following **to the Board**:
 - a) A valid Tennessee Driver's License, or photo ID issued by Department of Safety. **(Front Only)**
 - b) A valid driver license or ID issued by another state provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

Please submit a **copy** of one of the above not the original document.

7. If you checked "No" in question 4 please indicate from the list below which category applies to you:
(You must circle one)
- a) Permanent Residents
 - b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
 - c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
 - d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
 - e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d) (5) or whose deportation has been withheld under 8 U.S.C. 1253.
 - f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
 - g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a) (7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
 - h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c) (2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

The Tennessee Board of Nursing does not have a contract with the SAVE Program therefore you must submit two of the following forms of "documentation of identity and immigration status."

- I-327 (Reentry Permit)
- I-551 (Permanent Resident Card or "Green Card")
- I-571 (Refugee Travel Document)
- I-766 (Employment Authorization Card)
- Machine Readable Immigrant Visa (with Temporary I-551 language)
- Temporary I-551 stamp (on passport or I-94)
- I-94 (Arrival/Departure record)
- Unexpired foreign passport
- WT/WB Admission Stamp in unexpired foreign passport
- I-20 (Certificate of Eligibility for Nonimmigrant F (1) student status- "student visa")
- DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

AFFIDAVIT

I affirm under the penalty of perjury that the above is true and correct.

 Applicant Signature

Sworn to before me this _____ day of _____, 20_____.

AFFIX SEAL HERE

NOTARY PUBLIC SIGNATURE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.