



**Secretary of State
Office of Professional Regulation**

NURSING

Application Instructions for Advanced Practicing Registered Nurse– Re-Entry (Refresher)

In accordance with the Administrative Rules of the Vermont Board of Nursing, the following are required for Board approval of an APRN refresher program:

9-12 APRN Refresher Course

- (a) Individuals who have been out of practice for less than five years and who do not meet the practice requirement for initial licensure, or renewal, or reinstatement of an APRN license must take a refresher course as set forth in parts 9-16 through 9-18 of these Rules. Once commenced, the course must be completed within 18 months.
- (b) Individuals who have been out of practice for more than five and fewer than ten years may be assigned a case-specific refresher assignment approved by the Board;
- (c) Individuals who have been out of practice for more than ten years must complete a new post-masters APRN program that includes a minimum of 500 clinical practice hours.

9-13 Refresher Course Clinical Practice Permit.

The Board may grant a refresher course clinical practice permit, valid in six month increments and renewable not more than twice, to an applicant who:

- (a) holds a Vermont RN license;
- (b) holds a national APRN certification.

9- 14 APRN Refresher Course Design

- (a) Refresher programs may be individually designed or established by a nursing education program or a non-accredited nursing service facility. Each must be approved by the Board.
- (b) The Board may accept a Nationally Accredited Refresher Program in Vermont or elsewhere which meets the requirements of Parts 9-17 and 9-18 of these rules.
- (c) Refresher programs are available to APRNs who have been out of practice for ten years or less.

9-15 APRN Refresher Course Approval Criteria

The Board will approve a refresher program which:

- (a) for a licensee who has been out of practice for less than five years consists of a minimum of:
 - (1) 150 hours of theory; and
 - (2) 200 hours of clinical experience; or
- (b) for a licensee who has been out of practice for more than five years, but less than ten years consists of a minimum of:
 - (1) 150 hours of theory and
 - (2) 400 hours of clinical experience; and
- (c) which provides on-site supervision:
 - (1) by an APRN collaborating provider qualified under Part 9 of these rules holding a Vermont unencumbered APRN license, or a physician collaborating provider with a Vermont unencumbered license; and
 - (2) who practices in the same role and population focus.

9- 16 APRN Refresher Program Curricula. Curricula must include a review and update of:

- (a) advanced pharmacotherapeutics;
- (b) advanced assessment;
- (c) role and population specific theory and practice standards;
- (d) role and population specific clinical practicum; and
- (e) advanced practice nursing skills

1. Before completing an online re-entry application, applicants must submit an individually designed program, or a program established within a nursing education program, to the Vermont Board of Nursing for approval. Submissions to the Board should include a program summary, curriculum, preceptor names and credentials, and a plan for meeting clinical experience hours. Program submissions should be sent to SOS.OPRLicensing1@Vermont.gov
2. Once an applicant has had their refresher program approved by the Board, Re-entry Applicants must submit the following:
 - a. Complete the online Application for Advanced Practice Registered Nurse Re-entry (refresher).
 - b. Upload Board approved APRN Refresher Program documents
 - c. Submit Application Fee (Non-Refundable Processing Fee)
 - d. Upon refresher program completion, complete a RENEWAL application and upload a completed Evaluation of APRN Re-Entry Applicant Checklist

NOTE: Any change of address or other contact information, by an applicant or licensee, must be forwarded to this office no later than thirty (30) days after change occurs.

Section B: Refresher Program

Independent or School Affiliated Program: _____

Name of Parent Organization if applicable: _____

Physical Location if applicable: _____

Mailing Address if applicable: _____

Name of Program Director if applicable: _____

Name of Program Coordinator/Faculty If applicable : _____ Vermont License #: _____

The Re-Entry program consists of _____ hours of Theory and _____ hours of Clinical Practice.

Location of Clinical Practice Portion of Re-Entry Program: _____

Name and Title of Clinical Preceptor: _____

Vermont Nursing License number of Clinical Preceptor: _____

The clinical portion of the Re-Entry program will begin on:

_____ / _____ / _____ and will be completed on _____ / _____ / _____

MM DD YYYY MM DD YYYY

Signed by Applicant: _____ Date: _____

Signed by Clinical Preceptor: _____ Date: _____

Section C: Enclosures

Attach Board Approved APRN Refresher program plan

All required documents must be received by this office within 6 months of receipt of this application. If the application remains incomplete after 6 months, it will be destroyed. If you are interested in reapplying, a new application and fee must be submitted.

Statement of Applicant

I certify, under the pains and penalties of perjury, that all information I have provided in this application is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application or further disciplinary action. The maximum penalty for perjury is fifteen years in prison and/or a \$10,000 fine. (13 V.S.A. §2901)	
Signature of Applicant	Date

Send completed form to:

SOS.OPRLicensing1@vermont.gov

Evaluation of APRN Re-Entry Applicant Checklist

Instructions: This needs to be submitted and signed by the Re-Entry applicant and preceptors to verify the successful completion of both the theory and clinical practice portions of the Re-Entry program.

Applicant Name _____

Demonstrates an adequate theoretical knowledge base as defined in the program outline	Yes	No
Successfully completed 150 hours of Theory	Yes	No
Successfully completed 400 hours of Clinical Practice?	Yes	No
My signature below indicates that the aforementioned individual has demonstrated safe and competent practice in the role of: Identify Specialty		
1. Uses advanced health assessment skills to differentiate between normal variations of normal and abnormal findings.	Yes	No
2. Appropriately uses screening and diagnostic strategies in the development of diagnoses.	Yes	No
3. Appropriately Prescribes medications within the scope of practice	Yes	No
4. Appropriately manages the health/illness status of patients and families over time	Yes	No
5. Collaborates with both professionals and other caregivers to achieve optimal care outcomes.	Yes	No
6. Coordinates transitional care services in and across care settings	Yes	No
7. Demonstrates accountability for professional practice.	Yes	No
8. I, the undersigned authority, attest that the above information is true and correct and that I believe the above-named applicant is competent to practice in the full scope of the advanced practice role	Yes	No

I certify, under the pains and penalties of perjury, that all information I have provided is true and accurate. I understand that furnishing false information can constitute unprofessional conduct. (The maximum penalty for perjury is fifteen years in prison and/or a \$10,000 fine. 13 VSA §2901.)

Signed by Program Applicant _____ Date: _____

Signed by Preceptor _____ Date: _____