



Arkansas State Board of Nursing

University Tower Building
1123 South University Avenue, Suite 800
Little Rock, Arkansas 72204

PHONE 501.686.2700
FAX 501.686.2714
www.arsbn.org

REFRESHER COURSE TEMPORARY PERMIT APPLICATION INSTRUCTIONS

1. The applicant must obtain a temporary permit.
2. Complete the Refresher Course Temporary Permit Application and submit it to the Board office. Use blue or black ink or type to complete the application.
3. Attach the \$25.00 temporary permit fee to the application with a paperclip. In-state personal checks are accepted. Credit cards are accepted - see application for details. Please note that FEES ARE NON-REFUNDABLE.
4. Attach a copy of the acceptance letter from the refresher course.
5. Complete the Affidavit portion of the application before a Notary Public.
6. The temporary permit expires in **180 days** or upon completion of the Board approved refresher course. The temporary permit can only be used for activities directly related to the refresher course or competency-based orientation course. It may not be used for employment in any facility.

NOTE: All continuing education requirements must be met prior to issuance of an active license. If you are reinstating your Nursing license from an inactive status after an absence of greater than five years:

You must have completed 20 practice-focused continuing education contact hours **OR** hold certification by a national certifying body recognized by the Arkansas State Board of Nursing **OR** completed an academic course in nursing or related field **AND** have completed an ASBN approved refresher course or an employer competency orientation program.

FALSIFICATION OF THIS FORM IS GROUNDS FOR DISCIPLINARY ACTION
AGAINST YOUR LICENSE.

Check appropriate box:

RN LPN
APN LPTN
RNP

ARKANSAS STATE BOARD OF NURSING

UNIVERSITY TOWER BUILDING
1123 SOUTH UNIVERSITY, SUITE 800
LITTLE ROCK, ARKANSAS 72204
501.686.2700

FOR OFFICE USE
AR CERT. NO. _____
DATE _____

NURSING REFRESHER COURSE TEMPORARY PERMIT APPLICATION

Full Name _____
(MISS, MS., MRS., OR MR) FIRST MIDDLE MAIDEN LAST

Address _____
STREET CITY STATE ZIP

Mailing Address _____
STREET/P.O. BOX CITY STATE ZIP

Social Security Number _____ Telephone No. () _____ Date of Birth _____
MM/DD/YYYY

Place of Birth _____ Name & Phone No. of Nearest Relative _____

ETHNIC INFORMATION (check one): African American Asian Indian Asian Other Hispanic
(optional) Native American Pacific Islander White, not of Hispanic origin Other

Graduate of _____
NAME OF NURSING SCHOOL CITY STATE

Program Completion: Month _____ Year _____

Primary State of Residence _____ Initial State of Licensure _____

Type of inactive license(s) you hold: APN RNP RN LPN LPTN

State(s) & License Number _____

Name license issued under: (if different from above name, attach official documentation of name change)

Have you ever been convicted of a misdemeanor or felony or pled guilty or nolo contendere to any charge in any state or jurisdiction? YES NO (If yes, please include a copy of the court docket, plea agreement, or conviction papers, and evidence that fines, restitution are paid.) PLEASE NOTE: WITH THE EXCEPTION OF DWI, TRAFFIC VIOLATIONS DO NOT CONSTITUTE A CRIME

Have you ever had any license, certificate or registration disciplined (revoked, suspended, placed on probation or reprimanded) or voluntarily surrendered in any state or jurisdiction? YES NO (If yes, include copy of Facts and Finding from Board and evidence of reinstatement of license)

Are you currently under investigation in any state or jurisdiction? YES NO

Do you currently engage in drug-related behavior, including the use of mood-altering drugs/substances and/or alcohol that would affect your functional abilities to perform while working as a nurse? YES NO

Since your last renewal, have you been the subject of a chemical or alcohol dependency intervention or participated in chemical or alcohol dependency treatment/rehabilitation? YES NO (If yes, submit all relevant documents, such as rehab program completion, support group meetings, drug screens, etc.)

REFRESHER COURSE

Program Name _____ Enrollment Date _____

Program Address _____
STREET CITY STATE

Program Telephone Number () _____

Anticipated date of beginning clinical _____ Anticipated Date of Completion _____

