

**STATE OF UTAH**  
**DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING**  
**ADVANCED PRACTICE REGISTER NURSE**  
**(APRN) INTERN**

An APRN Intern license may be issued to:

1. An individual who meets all qualifications for a license as an advanced practice registered nurse except for the passing of required examinations if the applicant is a graduate of an approved nursing education program within the year immediately preceding application for an intern license; has never before taken the examination; and submits evidence of having secured employment conditioned upon issuance of the APRN intern license, and the employment is under the supervision of an advanced practice registered nurse or physician.
2. An applicant specializing in psychiatric mental health nursing upon completion of all licensure requirements, except for the passing of required examinations and completion of required clinical practice hours.

**APPLICATION INSTRUCTIONS AND INFORMATION:**

**General Statement:** The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents and fees.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial. The fees are for processing your application and will not be refunded. **Please read all instructions carefully.**

**Legal Name of Record:** You must apply under your legal name. Do not list nicknames on the application. According to the Code of Federal Regulations, 6 CFR 37.3, Title 6; Chapter I, Part 37, Subpart A, Full legal name means “an individual's first name, middle name(s), and last name or surname, without the use of initials or nicknames.”

**Address of Record:** The address provided on this application WILL BE YOUR ADDRESS OF RECORD. **Your address of record is your fixed permanent and principal home for legal purposes.** You **may not** list your place of employment as your address of record. All correspondence from DOPL will be sent to the address of record. You are responsible to directly notify DOPL of any change to your address of record. Do not rely on a forwarding order as state mail is not forwarded.

**Social Security Number:** A social security number is classified as a private record under the Utah Government Records Access and Management Act. It is used by DOPL as an individual identifier. It is also used for child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements 42 U.S.C. 666(a) (13). If a Social Security Number is not provided, the application is incomplete and may be denied.

**APPLICATION INSTRUCTIONS:**

<b>Mandatory Attachment Checklist</b> <i>(Applications with incomplete attachments will not be considered and may be denied.)</i>	
<input type="checkbox"/>	Submit a complete Division of Occupational Licensing (DOPL) APRN Intern application to the DOPL address listed below.
<input type="checkbox"/>	Submit a <b>\$75.00 Non-Refundable Application Processing Fee</b> , made payable to “DOPL.” This fee includes a \$35.00 APRN Intern application fee and a \$20.00 surcharge for a BCI fingerprint file search, and a \$20.00 surcharge for a FBI fingerprint file search.
<input type="checkbox"/>	Submit two applicant fingerprint cards (Form FD-258: white with blue lines) to be used by DOPL for a search through the files of the Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigation (FBI). If you bring your completed application to DOPL’s office at 160 E 300 S, Main Lobby, Salt Lake City, your fingerprints can be electronically scanned using DOPL’s Identix equipment.
<input type="checkbox"/>	Submit an official transcript documenting an <b>earned graduate degree</b> from an advanced practice registered nurse nursing education program. The official transcripts must include the graduation date and degree obtained, and document completion of coursework in advanced health assessment, diagnosis and treatment, and pharmacotherapeutics. The transcripts must also bear the school seal. Failure to submit an official transcript will result in denial of your application as incomplete. <ul style="list-style-type: none"> <li><input type="checkbox"/> An official transcript is included with this application in a sealed envelope, bearing the school’s stamp/seal on the envelope flap.</li> </ul>

<input type="checkbox"/>	Submit the “APRN Intern License Request” form ( <i>attached to this application</i> )
<input type="checkbox"/>	If you are applying as an APRN Intern <u>specializing in psychiatric mental health nursing</u> , also submit a completed “Psychiatric Mental Health Nurse: Post-Master’s Clinical Plan” ( <i>attached to this application</i> ).

**Important Additional Important Information:**

1. **Application Processing:** Processing time for an application, *where the fingerprints have been electronically scanned by DOPL and there are no issues that need to be resolved*, is approximately 7 to 21 business days if the application is complete. If the application is incomplete, the processing time will increase.
2. **License Prerequisite:** Before applying for licensure as an APRN Intern, you must hold a current registered nurse license in good standing issued by the state or be qualified at the time for licensure as a registered nurse. To be qualified at the time for licensure as a registered nurse means that you have been licensed as a registered nurse in Utah or another state. You do not need to apply for a registered nurse license if you hold a current Utah registered nurse license or a registered nurse license from another state.
3. **License Expiration:** An intern license is valid from the date of issuance until the earliest of the following dates:
 

**APRN:**

  - 180 days from the date of issuance. Once you have received your certification examination results you must have the certification body forward official verification to DOPL.
  - 30 days after the Division receives notice that the applicant has failed the examination. It is the professional responsibility of an APRN Intern to inform the Division of examination results within ten calendar days of receipt and have the examination agency send the examination results directly to the Division.

**APRN specializing in psychiatric mental health nursing:**

  - An Intern license issued to an APRN specializing in psychiatric mental health nursing shall be issued for a period of three years to allow for the completion of 3000 hours of supervised experience.
4. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The following laws and rules are available on the Internet at [www.dopl.utah.gov](http://www.dopl.utah.gov).
  - Division of Occupational & Professional Licensing Act, 58-1 (May 14, 2013)
  - General Rules of the Division of Occupational & Professional Licensing, R156-1 (August 22, 2013)
  - Nurse Practice Act, 58-31b (May 14, 2013)
  - Nurse Practice Act Rules, R156-31b (July 8, 2010)
  - Nurse Licensure Compact, 58-31c (January 1, 2000)
  - Nurse Licensure Compact Rule, R156-31c (August 16, 2010)
5. **Education Requirement:** You must complete an approved nursing education program as defined in the Nurse Practice Act Rules. The Nurse Practice Act Rules define an approved education program to include any nursing education program located within Utah that meets the standards established in statute and rule and any program located outside of Utah that also meets the standards established in statute and rule. Completion of a nursing education program is documented by submitting an official transcript that includes the date of completion and the degree earned. Completion of coursework in advanced health assessment, diagnosis and treatment, and pharmacotherapeutics must also be included on the transcripts.
6. **Updating Address Information:** It is your responsibility to maintain a current address with DOPL. If your address is incorrect, you will not receive correspondence from DOPL. Address changes can be made online at [www.dopl.utah.gov](http://www.dopl.utah.gov).

Please note that the Division of Occupational and Professional Licensing, section 58-1-301.7(1) Change of information reads:

- (a) An applicant, licensee, or certificate holder shall send the division a signed statement, in a form required by the division, notifying within 10 business days of a change in mailing address.
- (c) In addition to providing a mailing address, an applicant, licensee, or certificate holder may provide to the division, in a form required by the division, an email address and may designate email as the preferred method of receiving notifications from the division.

7. **Name Change:** If you have been licensed by DOPL under any other name, please submit documentation of your name change (*i.e. copy of a marriage license or divorce decree*).
8. **Fingerprint Information:** All applicants are required to undergo a criminal background check and fingerprint search through the files of the bureau of Criminal Identification (BCI) and the Federal Bureau of Investigation (FBI). To expedite the licensure process, you can obtain electronic fingerprinting at DOPL’s office at 160 E. 300 S., Salt Lake City,

8:00 a.m. to 4:30 p.m., Monday through Friday, except holidays. The cost for having fingerprints electronically scanned by DOPL is covered in the \$40 non-refundable surcharge fee. Applicants that arrive late in the day without leaving sufficient time to be processed will be turned away. A current government issued picture ID is required and would include one of the following: a driver's license issued by Washington D.C., a state of the United States of America or an identification card issued by the state of Utah.

If you are unable to obtain electronic fingerprints at DOPL's office, you must include two (2) blue fingerprint cards (Form FD-258) with your application for each individual associated with the application as defined above. **To have your fingerprints rolled onto the blue fingerprint cards, you must go to BCI, a local police station or an agency authorized by the FBI to roll fingerprints.** If you downloaded the application from the Internet, you may obtain fingerprint cards the Bureau of Criminal Identification (BCI), your local police station or authorized agency. *Fingerprint cards that are not complete and/or properly rolled will be rejected, delaying the licensure process.* **Due to the high number of inked fingerprint cards that are rejected and the amount of time it takes state and federal government agencies to process these cards, applicants are encouraged at the time of application to have their fingerprints electronically scanned at DOPL or at the Bureau of Criminal Identification.**

**Bureau of Criminal Identification (BCI) Information:**

- Check with BCI for pricing of their services
- Walk-ins only; no appointments taken
- Fingerprinting and Photo Services are available from 8:00 a.m. – 5:00 p.m., Monday - Friday except holidays
- Government-issued picture ID required (driver's license, state ID, passport, etc.)
- Address: 3888 W. 5400 S., Taylorsville, UT 84118 (1/2 block west of Bangerter Highway, behind McDonalds)
- Website: [www.bci.utah.gov](http://www.bci.utah.gov). Telephone number: (801) 965-4569

**Review of your FBI Record:** If you wish to challenge the accuracy of the information in your FBI record, you should contact the agency that contributed the information in question. You may also direct the challenge to the FBI, Criminal Justice Information Services (CJIS) Division, Attn. SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will forward the challenge to the respective agency.

9. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office. Credit card information is not accepted over the telephone.

10. Mail Complete Application to: **By U.S. Mail**  
Division of Occupational & Professional Licensing  
P.O. Box 146741  
Salt Lake City, Utah 84114-6741

**By Delivery or Express Mail**  
Division of Occupational & Professional Licensing  
160 East 300 South, 1<sup>st</sup> Floor Lobby  
Salt Lake City, Utah 84111

Telephone Numbers:  
(801) 530-6628  
(866) 275-3675 – Toll-free in Utah

**BLANK PAGE**  
(FOR TWO-SIDED PRINTING)



**State of Utah**  
**DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING**

160 East 300 South, P.O. Box 146741  
Salt Lake City, Utah 84114-6741  
Telephone (801) 530-6628  
[www.dopl.utah.gov](http://www.dopl.utah.gov)

**APRN INTERN**  
 **APRN INTERN SPECIALIZING IN PSYCHIATRIC  
MENTAL HEALTH NURSING**

**\*\*\*Please list your full legal name as it appears on your driver's license, Social Security Card, etc.\*\*\***

Last Name:	First Name:	Middle Name:
------------	-------------	--------------

Social Security Number:    -    -	Maiden Name:
-----------------------------------	--------------

I certify under penalty of perjury that:

- I am a citizen of the United States and I have a valid US Driver License or US State ID.  
License/State ID Number: \_\_\_\_\_ State: \_\_\_\_
- I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.
- I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID.  
License/State ID Number: \_\_\_\_\_ State: \_\_\_\_
- I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID. Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.
- I am a foreign national not physically present in the United States.

Mailing Address:

City:	State:	ZIP:
-------	--------	------

<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Phone #:	E-Mail Address:
--	----------------	----------	-----------------

***DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY***

License/Certificate/Exam approval Number: \_\_\_\_\_

Date License/Certificate/Exam approval - Approved: \_\_\_/\_\_\_/\_\_\_

Approved By: \_\_\_\_\_

Date License/Certificate/Exam approval Denied: \_\_\_/\_\_\_/\_\_\_

Denied By: \_\_\_\_\_

Reason for Denial/Other Comments: \_\_\_\_\_

Current Registered Nurse License: <input type="checkbox"/> Yes <input type="checkbox"/> NO		
Issuing State:	License Status:	
License Number:	Issue Date:	
List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. <i>(Use additional sheets if necessary.)</i>		
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
<input type="checkbox"/> I do not hold registrations, or certifications issued by any jurisdiction.		
<b>DECLARATION OF PRIMARY STATE OF RESIDENCE:</b>		
Primary State of Residence is the state of your declared fixed permanent and principal home for legal purposes; domicile.		
My primary state of residence will be:		

<b>PROFESSIONAL EDUCATION REQUIREMENT:</b> Please list most current first; use additional sheets if necessary.			
Name of Nursing Educational Program:			
Address of Program:			
City:		State:	Zip:
Dates Attended:	From:	To:	
Degree Received :		Date of Graduation:	
Specialty:			
Name of Nursing Educational Program:			
City:		State:	Zip:
Dates Attended:	From:	To:	
Degree Received:		Date of Graduation:	
Specialty:			

<b>COURSE WORK DOCUMENTATION</b>			
<input type="checkbox"/>	Advanced Health Assessment:		
	Name of School:		
	Course Number:	Date of Course Completion ( <i>Semester and Year</i> ):	
<input type="checkbox"/>	Diagnosis and Treatment:		
	Name of School:		
	Course Number:	Date of Course Completion ( <i>Semester and Year</i> ):	
<input type="checkbox"/>	Pharmacotherapeutics:		
	Name of School:		
	Course Number:	Date of Course Completion ( <i>Semester and Year</i> ):	

<b>NATIONAL CERTIFICATION EXAMINATION REQUIREMENT:</b>		
Certifying Body:		
Date Examination is Scheduled:	Specialty:	

# AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division of Occupational and Professional Licensing in conjunction with this application or its supporting documents meet the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division of Occupational and Professional Licensing or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for examination approval/licensure/certification/registration by the State of Utah.

Signature of Responsible Party: \_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Responsible Party: \_\_\_\_\_

## COMPLIANCE WITH UTAH LAWS AND RULES

I understand that it my continuing responsibility to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## APRN INTERN QUALIFYING QUESTIONNAIRE

**Read thoroughly, and answer the questions. Do not leave any question blank.**

(Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.)

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you ever been denied the right to sit for a licensure examination?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have you ever been permitted to resign or surrender a license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency or governmental agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is any action related to your conduct or patient care pending at any hospital or health care facility?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have you ever been permitted to surrender a registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Is any action now pending against you by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Have you been named as a defendant in a malpractice suit?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Have you ever been terminated from a position because of drug use or abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Are you currently using or have you recently ( <i>within 90 days</i> ) used any drugs ( <i>including recreational drugs</i> ) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which he has not successfully completed or is not now participating in a supervised drug rehabilitation program, or for which he has not otherwise been successfully rehabilitated?
<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Do you currently have any criminal action pending?

<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Have you ever pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
<input type="checkbox"/> Yes <input type="checkbox"/> No	28. Have you been allowed to plea guilty or no contest to any criminal charge that was later dismissed ( <i>i.e. plea-in-abeyance or deferred sentence</i> )?
	<p><b>If you answered “yes” to questions 24, 25, 26, 27 or 28 above, you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).</b></p> <p>If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.</p> <p>If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.</p> <p><b>If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.</b></p> <p><b>A “yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.</b></p>

**BLANK PAGE**  
**(FOR TWO-SIDED PRINTING)**

Utah Division of Occupational and Professional Licensing  
 160 East 300 South, P.O. Box 146741  
 Salt Lake City, Utah 84114-6741  
 FAX: (801) 530-6511

## APRN INTERN LICENSE REQUEST

### TO BE COMPLETED BY APPLICANT:

Name:	Telephone:		
Address:			
City:	State:	Zip:	Email:
Name of Certifying Exam:		Scheduled Date of Exam:	
Employing Facility:		Telephone:	
Address:			
City:	State:	Zip:	Email:
Date Employment Begins:			
I hereby certify that I will not practice until I have been granted an Intern license. Once the Intern license has been issued, I will practice under direct supervision of a supervising practitioner, or under general supervision if practicing as a psychiatric mental health nurse.			
<b>Signature of Applicant:</b>			<b>Date:</b>

### TO BE COMPLETED BY SUPERVISING PRACTITIONER(S):

Name:	Telephone:		
Address:			
City:	State:	Zip:	Email:
Position or Title:		License Number:	
<b>1.</b>	I hereby certify that I am a licensed practitioner in good standing and I will supervise the practice of the above named nurse. I understand that I must provide direct supervision, and shall be available on the premises at which the supervisee is engaged in practice. If I am supervising a psychiatric mental health nurse, I may be remote from the supervisee if there is personal direct voice communication.		
<b>Signature of Supervisor:</b>			<b>Date:</b>
<b>2.</b>	I hereby certify that I am a licensed practitioner in good standing and I will supervise the practice of the above named nurse. I understand that I must provide direct supervision, and shall be available on the premises at which the supervisee is engaged in practice. If I am supervising a psychiatric mental health nurse, I may be remote from the supervisee if there is personal direct voice communication.		
<b>Signature of Supervisor:</b>			<b>Date:</b>

Please note: The APRN Intern license expires the earlier of 180 days from the date of issuance; 30 days after the Division receives notice that the applicant has failed the certification examination; or upon issuance of the APRN license. If an intern is applying as a psychiatric mental health nurse, the intern license expires three years from the date of issuance. It is the professional responsibility of the APRN Intern to inform the Division of examination results within 10 calendar days of receipt and to cause the examination agency to send the certification results directly to the Division.

**BLANK PAGE**  
**(FOR TWO-SIDED PRINTING)**

Utah Division of Occupational and Professional Licensing  
 160 East 300 South, P.O. Box 146741  
 Salt Lake City, Utah 84114-6741  
 FAX: (801) 530-6511

**PSYCHIATRIC MENTAL HEALTH NURSE:  
 POST-MASTER'S CLINICAL PLAN**

**TO BE COMPLETED BY APPLICANT:**

Name:				Telephone:		
Address:						
City:	State:	Zip:	Email:			

**Project the number of hours of psychotherapy you will accomplish in each area.**

Individual Psychotherapy:	First Year:	Second Year:
Group Psychotherapy:	First Year:	Second Year:
Family Psychotherapy:	First Year:	Second Year:
Other Modality ( <i>specify</i> ):	First Year:	Second Year:

**According to the Nurse Practice Act Rule:**

(3) Requirements for APRN Specializing in Psychiatric Mental Health Nursing.

(a) In accordance with Subsection 58-31b-302(4)(g), the supervised clinical practice in mental health therapy and psychiatric and mental health nursing shall consist of a minimum of 4,000 hours of psychiatric mental health nursing education and clinical practice, including mental health therapy, as follows.

- (i) 1,000 hours shall be credited for completion of clinical experience in an approved education program in psychiatric mental health nursing.
- (ii) The remaining 3,000 hours shall:
  - (A) include a minimum of 1,000 hours of mental health therapy, with one hour of face-to-face supervision for every 20 hours of mental therapy services provided; and
  - (B) unless otherwise approved by the Board and Division, be completed while the individual seeking licensure is:
    - (I) employed by an approved health care provider; and
    - (II) under the supervision of an individual who meets the requirements of this Subsection (3).
- (iii) At least 2,000 hours must be completed under the supervision of:
  - (A) an APRN specializing in psychiatric mental health nursing; or
  - (B) a licensed mental health therapist who is delegated by the supervising APRN to supervise selected clinical experiences under the general supervision of the supervising APRN.
- (b) An applicant who obtains all or part of the clinical practice hours outside of Utah may receive credit for that experience by demonstrating that the training completed is equivalent in all respects to the training required under this Subsection (3).
- (c)(i) An approved supervisor shall verify practice as a licensee engaged in the practice of mental health therapy for not less than 4,000 hours in a period of not less than two years.
  - (ii) Duties and responsibilities of a supervisor include:
    - (A) being independent from control by the supervisee such that the ability of the supervisor to supervise and direct the practice of the supervisee is not compromised;
    - (B) supervising not more than three supervisees unless otherwise approved by the Division in collaboration with the Board; and
    - (C) submitting appropriate documentation to the Division with respect to all work completed by the supervisee, including the supervisor's evaluation of the supervisee's competence to practice.

**BLANK PAGE**  
**(FOR TWO-SIDED PRINTING)**

Utah Division of Occupational and Professional Licensing  
 160 East 300 South, P.O. Box 146741  
 Salt Lake City, Utah 84114-6741  
 FAX: (801) 530-6511

**VERIFICATION OF SUPERVISED EXPERIENCE  
 (FOR PSYCHIATRIC MENTAL HEALTH NURSES)**

**TO BE COMPLETED BY EACH SUPERVISOR OF THE REQUIRED SUPERVISED  
 EXPERIENCE HOURS:**

*NOTE: Only hours completed may be verified in this form. Do not include any projected hours.  
 This form to be submitted with the APRN Application*

Supervisors Name:		Telephone:	
Supervisors Profession:	License Number:	State:	Year Licensed:
Facility Name:			
Address:			
City:	State:	Zip:	Email:
Inclusive Dates of Supervised Experience:		From:	To:
Total Hours of supervised Experience in Mental Health Therapy(minimum 1,000 hours):			
Total Hours Face-to-Face Individual Supervision for Mental Health Therapy (minimum 50 hours):			
Total Hours of Supervised Experience (minimum 3,000 hours):			
Hours of Face-to-Face Individual Supervision Per Week:			
Hours Worked Per Week:			
<input type="checkbox"/> The hours worked and supervised are reported on the basis of the Supervisor's appointment calendars or records			
Nature of Applicant's Duties:			
Signature of Supervisor:		Date:	

According to the Nurse Practice Act Rule requirements for APRN Specializing in Psychiatric Mental Health Nursing:

(a) In accordance with Subsection 58-31b-302(4)(g), the supervised clinical practice in mental health therapy and psychiatric and mental health nursing shall consist of a minimum of 4,000 hours of psychiatric mental health nursing education and clinical practice, including mental health therapy, as follows.

(i) 1,000 hours shall be credited for completion of clinical experience in an approved education program in psychiatric mental health nursing.

(ii) The remaining 3,000 hours shall:

(A) include a minimum of 1,000 hours of mental health therapy, with one hour of face-to-face supervision for every 20 hours of mental therapy services provided; and

(B) unless otherwise approved by the Board and Division, be completed while the individual seeking licensure is:

(I) employed by an approved health care provider; and

(II) under the supervision of an individual who meets the requirements of this Subsection (3).

(iii) At least 2,000 hours must be completed under the supervision of:

(A) an APRN specializing in psychiatric mental health nursing; or

(B) a licensed mental health therapist who is delegated by the supervising APRN to supervise selected clinical experiences under the general supervision of the supervising APRN.

(b) An applicant who obtains all or part of the clinical practice hours outside of Utah may receive credit for that experience by demonstrating that the training completed is equivalent in all respects to the training required under this Subsection (3)

- (c) (i) An approved supervisor shall verify practice as a licensee engaged in the practice of mental health therapy for not less than 4,000 hours in a period of not less than two years.
- (ii) Duties and responsibilities of a supervisor include:
- (A) being independent from control by the supervisee such that the ability of the supervisor to supervise and direct the practice of the supervisee is not compromised;
  - (B) supervising not more than three supervisees unless otherwise approved by the Division in collaboration with the Board; and
  - (C) submitting appropriate documentation to the Division with respect to all work completed by the supervisee, including the supervisor's evaluation of the supervisee's competence to practice.