Memo

To: Advanced Practice Registered Nurses and Registered Professional Nurses

From: Virgin Islands Board of Nurse Licensure: Ann Douté, MSN, RN, Chairperson

Date: June 2017

Re: Renewal of Advanced Practice Registered Nurses and Registered Professional Nurses Registration Licenses

All nurses are responsible for the biannual renewal of nursing registration licenses/certificates even though a renewal application might not have been received.

Renewal applications are available from the office of the Virgin Islands Board of Nurse Licensure (VIBNL) and the Human Resources departments at the Governor Juan F. Luis Medical Center and Schneider Regional Medical Center.

Note: Renewal Applications for Registration Certificates for the 2018-2019 biennium will be mailed beginning in July 2017. Completed renewal packets must be returned to the VIBNL for processing as soon as applicants have fulfilled all requirements for renewal as stipulated.

Office Hours: Regular office hours are Monday through Friday, 8:30 am – 4:00 pm. The Board’s office will be closed to public for the end of the year reconciliation from December 18th, 2017 through January 2nd, 2018, and will reopen on January 3rd, 2018.

Application Deadline: Although current biennium Registration Certificates do not expire until December 31st, 2017, to ensure receipt of your 2018-2019 Registration Certificate prior to the date of expiration, renewal applications must be received by the VIBNL no later than October 31, 2017. This allows adequate time for the VIBNL to complete administrative review, issuance, and mailings of your Registration Certificate prior to December 31, 2017. Registration Certificates for the 2018-2019 biennium may not be processed by January 1st, 2018 if applications are received by the VIBNL after October 31st, 2017.

It is a violation of the Virgin Islands Code to work with a lapsed Registration Certificate (License). See Lapsed Registration below for further information.

Registration Fee: The fee for renewal of Registration Certificates (Licenses) is as follows:

- Registered Nurse: $125.00
- Advanced Practice Registered Nurse: $150.00
- Inactive Fee $15.00

Fees are payable only by U.S. Postal Service money order, certified bank check, or credit or debit card. Note: Only transactions made in person at the office of the VIBNL are payable by credit and debit cards. Fees are Non-Refundable and Non-Transferrable.
**Lapsed Registration: Completed** renewal applications postmarked after December 31, 2018 will be considered **LAPSED**. All lapsed applicants will incur a penalty fee of $200.00 which they will be required to submit with their renewal fee in order to reactive their license.

**Inactive Status:** Nurses who apply for an Inactive Registration Certificate (License) must complete a renewal application card and submit the inactive registration fee of $15.00 before December 31st of the renewal year. If not renewed by December 31st, 2018 there will be an additional $200.00 lapsed registration fee plus the $15.00 inactive fee. Any license that has been inactive for more than ten (10) years shall automatically be suspended. Applicants must submit all documents required for an active license upon request for re-activation.

**Refresher Courses:** Nurses who have not practiced nursing during the last five (5) years, must complete a one-hundred and sixty (160) hour refresher course that includes both theory and clinical hours pre-approved by the VIBNL.

**Continued Competency:** The regulations for continued competency for renewal of a registration certificate include **COMPLETION OF TWO (2) OF THE FOLLOWING:**

1. **RN:** Fifteen (15) contact hours of continuing education. 1.5 hours of these hours are mandated to be related to prevention of medical errors. The 15 contact hours may be obtained online, by attending workshops, or through individual study (e.g. certification preparation).

   **DOCUMENTATION OF THE FIFTEEN (15) CONTACT HOURS are to be listed on the continuing Education Form provided by the Board and must include a provider number and copies of certificates of completion. If contact hours are not listed, the renewal application will be considered INCOMPLETE and it will be returned to the applicant.**

   **APRN:** Thirty (30) contact hours of continuing education within area of practice specialty and submission of proof of current national certification within that specialty. **A TOTAL OF THIRTY (30) CONTACT HOURS are to be listed on the Continuing Education Form provided by the Board and must include a provider number and copies of certificates of completion. If contact hours are not listed, the renewal application will be considered INCOMPLETE and it will be returned to the applicant.**

2. **Three hundred twenty (320) hours of active nursing practice** in the previous biennium which must be certified by the supervisor or designee on the Employer Verification form provided by the Board. APRNs are requested to submit an updated Collaborative Agreement.

   **“OR” …**

3. **Participation in fifteen (15) hours of approved professional activities** documented and certified by supervisor, client or manager of the activity, or organization on the **Professional Activity Form** obtainable from the VIBNL.

**New Graduates:** Nurses who graduated and received their initial license during the prior biennium are not required to complete the continuing education requirements for the renewal. Nursing classes taken during this period must be listed on the CEU form.

**Signature:** Signature and date of signature must be included on all renewal forms or the application will be considered incomplete and will not be processed.
**Name Change:** The VIBNL must be notified immediately in writing of any change of name and must include official supporting documentation (e.g. marriage license).

**Address Change:** The VIBNL must be notified immediately in writing of any change in address and/or telephone number. Changes may be faxed to the VIBNL at (340) 777-4003.

**Tax Status:** The Stop Tax Clearance Letter from the United States Virgin Islands Bureau of Internal Revenue is no longer required for the renewal process.

**Official Verification:** Lapsed and Inactive applicants not residing within the territory of the US Virgin Islands are required to submit an Official Verification of an unencumbered nursing license that is valid for at least 90 days from the date on the renewal application. Obtainable at www.Nursys.com. A copy of an unencumbered nursing license must be included with the renewal application.

**Discipline:** Self disclosure is required for all misdemeanors, felonies, plea agreements (even if adjudication was withheld), and any substance use disorder within the last five (5) years. Any complaint or disciplinary actions taken or pending against your professional or occupational license, registration, or certification must be disclosed. Failure to do so may result in a disciplinary action by the VIBNL.

**Communication:** Should you have questions, need clarification, or directions to the office of the VIBNL, please do not hesitate to contact the Board staff. We are committed to keeping you informed about the renewal of your registration. Our numbers are: Phone: (340) 776-7397 and Fax: (340) 777-4003.

**Note:** Please use the following address when forwarding overnight parcels to the VIBNL.

1. FEDEX/UPS parcels: #3 Kongens Gade, Old Justice Complex, St. Thomas, USVI 00802
2. US Postal Service: 5051 Kongens Gade Suite 1, St. Thomas, USVI 00802-6487
Application for Renewal Registration to Practice as a Licensed Practical Nurse / Registered Nurse / Advanced Practice Registered Nurse (NM, CNM, CM, CRNA, NP)

GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS
DEPARTMENT OF HEALTH
Virgin Islands Board of Nurse Licensure

Physical Address: 5051 Kongens Gade Suite 1, St Thomas, USVI 00802 / Mailing: PO Box 304247, St. Thomas, USVI 00803 / Tel# (340) 776-7997 Fax (340) 777-4003

NAME: __________________________ (APRN/RN/LPN) MAILING ADDRESS __________________________ 

LICENSE NO. __________________________ TEL#/s __________________________ (H) __________________________ (W) __________________________ 

SOCIAL SECURITY NUMBER __________________________

D.O.B. __________________________

(PLEASE CIRCLE THE ANSWER)
SEX: MALE/FEMALE
MARITAL STATUS: S / M / W / D
U.S. CITIZEN: Y / N

EMPLOYMENT STATUS (CIRCLE ONE)
1. FULL-TIME
2. PART-TIME (LESS THAN 40HRS A WEEK)
3. AVERAGE HOURS PER WEEK WORKED IN THE PAST
24 MONTHS________________________
12 MONTHS________________________
4. UNEMPLOYED (YES /NO)

PRINCIPAL FIELD/PLACE OF EMPLOYMENT (CIRCLE ONE)
1. HOSPITAL (ST. THOMAS, ST. JOHN, ST. CROIX)
2. NURSING HOME (ST. THOMAS/ST. CROIX)
3. SCHOOL OF NURSING
4. PRIVATE DUTY
5. SCHOOL NURSE (ST. THOMAS, ST. JOHN, ST. CROIX)
6. HOSPICE FACILITY (ST. THOMAS/ST. CROIX)
7. OCCUPATIONAL HEALTH NURSE (ST. THOMAS/ST. CROIX)
8. OFFICE NURSE (PHYSICIAN OR DENTIST)
9. COMMUNITY HEALTH (ST. THOMAS, ST. JOHN, ST. CROIX)
10. SELF-EMPLOYED OTHER THAN PRIVATE DUTY
11. OTHER (EXPLAIN)________________________

Has there been any complaints or disciplinary action taken or pending against your professional nursing or occupational license, registration, or certification? Yes ( ) No ( )

If Yes, Where __________________________ License # __________________________ Please attach explanation and supporting documents.

You must disclose all misdemeanors, felonies, plea agreements (even if adjudication was withheld), any substance use disorder in the last five (5) years, and any actions taken or initiated against a professional or occupational license, registration, or certification is required on a separate piece of paper.

Failure to disclose information will result in license not being renewed.

(Over)

CURRENT POSITION
1. CHAIRPERSON/DIRECTOR/ASSISTANT
2. ADMINISTRATOR/ASSISTANT
3. CONSULTANT
4. SUPERVISOR/CLINICAL CARE COORDINATOR
5. INSTRUCTOR/PROFESSOR
6. HEAD NURSE OR ASSISTANT
7. REGISTERED NURSE
8. NURSE/ASSOCIATE/PRACTITIONER (PNP, FNP, NP)
9. CLINICAL SPECIALIST
10. SCHOOL NURSE
11. CERTIFIED REGISTERED NURSE ANESTHETIST, CRNA
12. CNM, CM, CRN
13. LICENSED PRACTICAL NURSE
14. OTHER __________________________

PLEASE INDICATE YES OR NO IF THE FOLLOWING REQUIREMENTS WERE COMPLETED BY DEC. 31ST OF THE RENEWAL YEAR:

COMPLETED THIS CARD FRONT AND BACK: ______
INCLUDED THE PROCESSING FEE: ______
STATUS REQUESTED BEFORE 12/31/____ TO ____
( ) ACTIVE ( ) INACTIVE

TWO OF THREE COMPETENCIES:
EMPLOYMENT VERIFICATION ______
"OR" PROFESSIONAL ACTIVITY FORM ______
& CEU FORMS PROVIDED ARE COMPLETED, SIGNED, AND DATED ______

SIGNATURE __________________________ DATE __________________________

Physical Address: 5051 Kongens Gade Suite 1, St Thomas, USVI 00802 / Mailing: PO Box 304247, St. Thomas, USVI 00803 / Tel# (340) 776-7997 Fax (340) 777-4003

Updated 07/21/2016

OFFICE USE

PAID: ______
RENEW: ______
REGISTRATION: ______
DO NOT RENEW: ______
BOARD REVIEW: ______
CONTINUING EDUCATION RECORD FOR REGISTERED PROFESSIONAL NURSE/LICENSED PRACTICAL NURSE

Please Print or Type

<table>
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<tr>
<th>LICENSEE NAME</th>
<th>LICENSE NUMBER</th>
<th>SOCIAL SECURITY #</th>
<th>DATE OF BIRTH</th>
<th>TELEPHONE #</th>
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CONTINUING EDUCATION ACTIVITIES COMPLETED:

(NAME OF CEU OFFERING) TO (NAME OF CEU OFFERING)

(MONTH/ YEAR) TO (MONTH/ YEAR)

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<tr>
<th>NAME OF CEU OFFERING</th>
<th>COMPLETE NAME OF ORGANIZATION/INSTRUCTOR CONDUCTING THE COURSE</th>
<th>PROVIDER NUMBER</th>
<th>LOCATION (HOME STUDY, LOCALLY, NATIONALLY)</th>
<th>DATES OF CEU OFFERINGS (MM/DD/YYYY)</th>
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PLEASE NOTE:

VIBNL RECOGNIZES THESE COURSES AS FOLLOWS: CPR 3, BCLS 3, PALS 5, ACLS 5.
APRNs, RNs, & LPNs ARE RECOMMENDED TO EARN 1.5 CONTACT HOURS IN HIV/AIDS EDUCATION.

I hereby certify that all above statements are true:

______________________________  __________________________
SIGNATURE                       DATE

OFFICE USE ONLY:

REVIEWED BY: _____________________  DATE
A=APPROVED  D=DISAPPROVED  B=BOARD REVIEW  AU=AUDITED

Rev: 04/12, 10/13
License Renewal Verification of Employment Form

Licensees please complete only the top portion of this form. Obtain your employer’s signature below.

I, ____________________________ am complying with the requirements for renewal of my United States Virgin Islands Nursing Registration to practice as a ____ Registered Nurse, ____ Licensed Practical Nurse, ____ Advance Practice Registered Nurse and hereby authorize you to release information as required on this form.

Current Address: ____________________________________________________________

License Number: ________________________ Social Security Number ___________________
Include a legible copy of your current license if you did not practice on the United States Virgin Islands during the past two (2) years.

Employers please complete the following:

____________________________________ worked 320 hours or more as an APRN / RN / LPN at
(Name of Applicant) (Circle One)

Address of Facility: __________________________________________________________
Period of Employment: ______________________ Tel.# ___________________

Did the position require the employee to hold a current APRN/RN/LPN license? ___Yes ___No
Reason for not earning 320 hours or more: __________________________________________________________________________________

Verified by __________________________ Date ____________
(Signature of Supervisor, Human Resources Manager, Clinical Care Coordinator, Recruiter of Registered Nurse or Practical Nurse).

(Print Name) (Title)

Rev. 08/2014
AGREEMENT OF COLLABORATIVE RELATIONSHIP
Between
________________________________________, MD
________________________________________, MSN, APRN

This Agreement of Collaborative Relationship has been made and is now duly written
between ___________________________________, MD and _____________________________.
APRN as of this _____________ day of __________, __________. Said agreement which is
being submitted as a required of the Virgin Islands Board of Nurse Licensure (VIBNL), shall
show the intent for the following mutual collaborative responsibilities between the Advanced
Practice Registered Nurse (APRN) and the Physician.

1. The Physician agrees to be available to the APRN for consultation collaboration and
   referral as necessary.

2. The APRN agrees to practice within the Scope of Practice as defined in the Rules and
   Regulations established by the Virgin Islands Board of Nurse Licensure.

3. Both parties agree to maintain high ethical and professional standards.

   It is understood that any changes in this Agreement must be submitted to the VIBNL
   within 30 days of the change.

Respectfully Submitted,

_____________________________                                        _____________________________
Print Name of Physician                                                Print Name of APRN

_____________________________                                        _____________________________
Signature of Physician                                                   Signature of APRN

___________________________                        _____________________________
Witness                                                               Date

Rev: 10/07, 10/13
GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS

DEPARTMENT OF HEALTH
Virgin Islands Board of Nurse Licensure
P.O. Box 304247
St. Thomas, Virgin Islands 00803
Tel: (340) 776-7397
Fax: (340) 777-4003

PROFESSIONAL ACTIVITY FORM

Complete the top portion of this form and mail it to the organization/agency where the professional activities were performed for completion.

I, ___________________________________________ am complying with the competency requirements of my nursing registration to practice as an _____ Advance Practice Registered Nurse _____ Registered Nurse or _____ Licensed Practical Nurse and hereby authorize you to release information as required on this form.

Name: _______________________________________________________________________
SSC#: ______________________________________________________________________
Mailing Address: _______________________________________________________________________
Tel#: ______________________________________________________________________

Signature __________________________
______________________________________________________________________________

EMPLOYER / ORGANIZATION / ASSOCIATION
Please complete the information below:

This is to verify that ___________________________ performed ____________________ hours
of work/volunteer activity for __________________________________________________________

Date: ____________________________________________________
(Address)

The nature of the work/volunteer activity was ________________________________________________

Date of Completion ________________________________________________

Verified by __________________________ (Print Name) __________________________ (Date)

(Signature) __________________________ (Title/Position)
Section A  Competencies

1. CEUs – Five (5) of fifteen required contact hours must be obtained through seminars or a formalized continuing education offering (i.e. professional association conventions, board approved community based offerings, university offerings).

2. Nursing practice – a minimum of 320 hours of nursing practice per biennium documented by the immediate supervisor on the form provided by the board.

3. Professional Activities – 15 hours of participation in a professional activity.
   a) Active participation as an officer in a professional nursing or health related association.
   b) Authoring or contributing to an article, book, or publication related to health care.
   c) Development and oral presentation of a paper before a professional or lay group on the subject that explores new and current areas of nursing theory, technique, or philosophy.
   d) Design and conduct of a research study relating to nursing and health care.
   e) Volunteering or community service related to nursing.
   f) Full time and private duty nursing – non registry – (Client or Relatives).
   g) Full time private duty nursing with a professional licensed registry.
   h) Examiners, proctors, and raters for licensing and or certification exams.
   i) Other professional activities approved by this board before December 11th in the second year of the biennium.
   j) Other professional activities approved by this board.

Section B  Alternative Methods for Meeting Competency Requirements

A nurse may meet continued competency requirements by providing the board with documentation of one of the following:

1. Completed a board approve refresher course consisting of not less than 160 hours of instructor planned, supervised instruction including theory at a ratio of 60 minutes of instruction per one hour credit and clinical practice at a ratio of three hours of practice per one hour of credit; or earned three or more nursing credited hours;

2. Attained a degree or certificate in nursing, or made progress toward one beyond the educational requirements for the nurses original license by successfully completing two required course;

3. Successfully completing the National Council of State Boards of Nursing Licensing Examination (NCLEX/CAT);

4. Meeting certification requirements for specialty areas in nursing and maintaining current certification in the specialty.