



CERTIFICATE OF AUTHORITY (COA) INSTRUCTIONS AND REQUIREMENTS

Eligibility for a COA to practice as a Certified Nurse Midwife (CNM), Certified Nurse Practitioner (CNP), Certified Nurse Specialist (CNS) or Certified Registered Nurse Anesthetist (CRNA) in Ohio requires the possession of a valid Ohio RN license. The following must be submitted to the Ohio Board of Nursing (Board), attention: APRN Unit:

Complete the entire application in ink or typed print. **PLEASE PRINT LEGIBLY.**

1. Non-Refundable Application Fee

A **\$100 non-refundable fee** payable to “Treasurer, State of Ohio” must accompany this application. Send a certified check, cashier’s check or money order. Personal checks or cash will not be accepted. Business checks from government entities, corporations, and education or training programs will be accepted. Payments must be drawn on a United States (U.S.) bank payable in U.S. dollars. Please do not staple your payment to the application. If the submitted fee does not meet the requirements, the entire application will be returned to you.

2. Verification of National Certification

A list of Board-approved national certifying organizations is available on the Board’s website. Please request that verification be sent directly to the Board by mail (see address above), attention: APRN Unit, or by email (aprn@nursing.ohio.gov).

3. Education Verification

Education verification of a graduate degree with a major in a nursing specialty or in a related field that qualifies you to sit for a national certification examination. The education program must send a signed and sealed transcript **directly** to the Board via mail. Electronic transcripts or transcripts sent by the applicant will not be accepted. The degree or certificate, and date of completion must be indicated on the transcript.

Processing Information

Applications, Documents and Processing Time

Applications may be submitted before you finish your APRN education, or before you take your certification examination. Applications are maintained on file for a year, and application documents will be added to your file as they arrive. If the application remains incomplete for one year, the application will be considered void and the fee will be forfeited.

Submitting RN, COA and Certificate to Prescribe Externship (CTP-E)/Certificate to Prescribe (CTP) Applications Together

RN, COA and CTP-E or CTP applications can be mailed in together; however, you are not eligible for a COA until your RN license has been issued, and you are not eligible for a CTP-E or CTP until your COA has been issued. You cannot combine the fees when you send in multiple applications. Each application requires a separate payment.

Verifying Receipt of Application

To determine if your application has been received, please go to the Board’s website at www.nursing.ohio.gov, click on “verification” and enter your name. Once your name appears, it will display as “pending” until a COA is issued. If any part of this application is incomplete, the application may be returned.

Please contact us for any additional questions via e-mail at aprn@nursing.ohio.gov



Ohio Board of Nursing

www.nursing.ohio.gov

17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

Advanced Practice Registered Nurse (APRN) Application Certificate of Authority (COA)

Mail application and fee to address above, attention: APRN Unit

\$100 fee made payable to "Treasurer, State of Ohio" submitted in the form of a:

- Certified Check
 - Cashier's Check
 - Money Order
 - Business check from government entity/corporation/education/training program
- (Personal checks are not acceptable by the Board)*

Applying to be a (Check one):

- Certified Nurse-Midwife (CNM)
- Clinical Nurse Specialist (CNS)
- Certified Nurse Practitioner (CNP)
- Certified Nurse Anesthetist (CRNA)

Full Legal Name _____
Last First Middle Maiden

Social Security Number* _____ Date of Birth _____

Address _____ City _____

State _____ Zip Code _____ County _____

Telephone Number _____ Email Address _____

Ohio RN# (If you do not have an Ohio RN license, you must apply for one) _____

GENDER Female Male

RACE/ETHNICITY (If more than one applies, mark "other.")

- African American/Black
- American Indian or Alaska Native
- Asian-Indian
- Caucasian/White
- Hispanic/Latino
- Native Hawaiian or Other Pacific Islander
- Other
- Asian
- I do not wish to furnish this information

MILITARY(check if applicable)

I am a member or former member of the armed forces of the United States, the national guard or a reserve component (attach a copy of a military document, for example, an ID card (DD Form 2) or Certificate of Release or Discharge from Active Duty (DD Form 214)).

I am the spouse of a member or former member of the armed forces of the United States, the national guard or a reserve component (attach a copy of your spouse's military document, for example, an ID card (DD Form 2) or Certificate of Release or Discharge from Active Duty (DD Form 214)).

* Your social security number is required by state and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the National Practitioner Data Bank (Public Law 100-93, Sec. 1921 of the Social Security Act, as amended; 45 C.F.R. pt. 60); reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

PREVIOUS LICENSURE

Have you ever practiced as a CNM, CNP, CNS or CRNA in **another** state or U.S. territory? Yes No

The Board must verify that you hold a license or certificate in good standing in another jurisdiction to practice as a CNM, CNP, CNS or CRNA. Please provide the state and the license/certificate number(s). Attach a separate sheet if needed.

State	License/Certificate #	Issue Date	Expiration Date

APRN EDUCATION

Name of School _____

Completion Date _____ Name Under Which You Graduated _____

Type of Program Certificate Diploma Master’s Post Master’s Certificate Doctoral

NATIONAL CERTIFYING ORGANIZATION Please request that verification be sent directly to the Board by mail (see address above), Attention: APRN Unit, or email. If you have not yet taken the exam, provide the information you have.

Organization Name _____ Specialty _____

Expiration Date _____ Name Under Which You Were Certified _____

OHIO COLLABORATING PHYSICIAN/PODIATRIST PRACTICE INFORMATION

Have you ever been certified to practice as a CNM, CNP, CNS or CRNA in Ohio?

Yes. COA number(s) _____

No.

I will provide to the Board (by fax, email or letter) the name and business address of each collaborating physician/podiatrist within thirty days after first engaging in practice. I will provide the Board the names and business address of any new or discontinued collaborating physicians/podiatrists within 30 days after the change takes effect.

Each CNM, CNP, or CNS practicing in Ohio must identify all collaborating physicians and/or podiatrists. In addition to identifying a collaborating physician or podiatrist, each COA holder is required to enter into a standard care arrangement (SCA) with the collaborating physician or podiatrist before engaging in practice. The SCA must be signed by the nurse and each collaborating physician or podiatrist, and be retained and available upon request at each practice site. **The Board does not provide a SCA template**, however the information that must be included in a SCA can be found at the following: (<http://codes.ohio.gov/oac>) Search: 4723-8-04

A CNS without a certificate to prescribe (CTP) whose nursing specialty is mental health or psychiatric mental health practicing in Ohio must identify all collaborating physicians but is not required to have a SCA. (<http://codes.ohio.gov/oac>) Search: 4723-8-04

(Attach a separate sheet if needed)

Name of collaborating physician/podiatrist _____

Business Address (include city, state and zip code) _____

Name of collaborating physician/podiatrist _____

Business Address (include city, state and zip code) _____

COMPLIANCE (Application will be returned if any question is left unanswered)

Please circle "Yes" or "No" to each question. Your application is **not** complete until the Board has received **ALL** required documents.

CAUTION: False, and/or misleading information provided by an applicant may result in the denial/permanent denial of a nursing license/certificate.

Have you EVER been convicted of, found guilty of, pled guilty to, pled no contest to, pled not guilty by reason of insanity to, entered an Alford plea, received treatment or intervention in lieu of conviction, or been found eligible for pretrial diversion or a similar program for any of the following crimes. This includes crimes that have been expunged IF there is a direct and substantial relationship to nursing practice? Answer "Yes" or "No" to EACH question			
1a.	A felony in Ohio, another state, commonwealth, territory, province, or country? <i>If you answer "Yes", enter the court and case number.</i> Court Name: _____ Case#: _____	Yes	No
1b.	A misdemeanor in Ohio, another state, commonwealth, territory, province, or country? This does not include traffic violations unless they are DUI/OVI or Physical Control While Under the Influence. <i>If you answer "Yes", enter the court and case number.</i> Court Name: _____ Case#: _____	Yes	No
2.	Have you been found to be a mentally ill person subject to hospitalization by court order, been found to be mentally incompetent by a probate court, or been found incompetent to stand trial by a court?	Yes	No
If you answered "Yes" to a box above, you are required to provide the Board with a written explanation of the events including the date, county and state in which the events occurred (attach a separate sheet to this application), and a certified copy of the indictment(s) or criminal complaint(s), plea(s), journal entry(s) from the appropriate court. A copy of the court docket or case summary does not meet this requirement.			
3.	Has any board, bureau, department, agency or other body, including those in Ohio, other than this Board, in any way limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you? Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate, or registration?	Yes	No
4.	Have you ever, for any reason, been denied an application, issuance or renewal for licensure, certification, registration, or the privilege of taking an examination, in any state (including Ohio), commonwealth, territory, province, or country?	Yes	No
5.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, certificate, or registration in lieu of or in order to avoid formal disciplinary action with any board, bureau, department, agency, or other body, including those in Ohio, other than this Board?	Yes	No
6.	Have you been notified of any current investigation of you, or have you ever been notified of any formal charges, allegations, or complaints filed against you by any board, bureau, department, agency, or other body, including those in Ohio, other than this Board, with respect to a professional license, certificate, or registration?	Yes	No
If you answered "Yes" to questions 3-6, you are required to provide the Board with a written explanation and certified copies of any documents.			
7.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	Yes	No
8.	Within the last five years, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	Yes	No
9.	Have you, since attaining the age of eighteen or within the last five years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	Yes	No
If you answered "Yes" to questions 7- 9, you are required to provide a written explanation, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.			
10.	Are you currently engaged in the illegal use of chemical substances or controlled substances? For this question " Currently " does not mean on the day of, or even weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a certificate holder or licensee, or within the past two years. " Illegal use of chemical substances or controlled substance" means the use of chemical substances or controlled substances obtained illegally (e.g. heroin, cocaine, or methamphetamine) as well as the use of controlled substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the direction of a licensed healthcare practitioner.	Yes	No
a.	If you answered "Yes" to question 10 , are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not illegally using chemical substances or controlled substances? <i>If you answered "Yes", you are required to provide a written explanation.</i> If you are participating in a monitoring program, you are required to cause the respective program to provide information detailing your participation in and compliance with the program.	Yes	No
11.	Are you required to register, under Ohio Law, the law of another state, the U.S., or a foreign country, as a sex offender?	Yes	No

Last Name

First Name

Middle

(Print clearly, your full legal name as it appears on the first page of the application)

Certificate of Authority Attestation

I am the person in this application for Certificate of Authority and the statements made herein and the documents submitted are true and accurate.

I will maintain certification by national certifying organization approved by the Board in a designated area of advanced nursing practice. I understand that my certificate of authority will be automatically suspended if I fail to maintain and provide documentation to the Board of current, valid certification.

I understand that as a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist (except for clinical nurse specialists whose nursing specialty is mental health or psychiatric mental health, as determined by the Board) I must practice only in accordance with a standard care arrangement entered into with one or more collaborating physicians or podiatrists. The standard care arrangement must comply with the criteria specified in Section 4723.431 of the Revised Code and Chapter 4723-8 of the Administrative Code. I further understand that the standard care arrangement shall be retained on file and be available upon request at each site of my practice.

If I have not identified a collaborating physician/podiatrist, I will provide the Board the name and business address of each collaborating physician/podiatrist within 30 days after first engaging in practice. I will provide the Board the names and business address of any new or discontinued collaborating physicians/podiatrists within 30 days after the change takes effect.

I have read and understand this Attestation and I am aware that misrepresentation on this application may result in disciplinary action in accordance with Section 4723.28 of the Revised Code.

I hereby request that in order to process my application, act upon renewal requests, and respond to public requests to confirm my license/certificate status, my personal information be accessed in accordance with OAC 4723-1-11 (D)(2)(d)(ii).

Printed Legal Name of Applicant

(Application will be returned if name is not printed)

Legal Signature of Applicant

(Application will be returned if name is not signed)

THIS SIDE BOARD USE ONLY

ITEMS RECEIVED

- Graduate degree
- Post-master's (if applicable)
- National Certification
- Yes No Out of state nurse
- Verification of good standing

NOTES _____