

NURSE ACQUISITION FORM

Please complete this form and return to Admin@MedicalLicensureGroup.com.

Contact Information

Name (First Middle Last Suffix) _____ Application Type _____

Maiden or Previous Name(s) _____

Date of Change _____ Reason for Change _____

Home Address _____ City, State Zip _____

Work Address _____ City, State Zip _____

Home Email _____ Cell Phone _____

Work Email _____ Work Phone _____

Other Contact _____ Home Phone _____

Preferred Contact Method Work Cell/Home Work Email Home Email

Preferred Mailing Address Work Home

Identifying Information

Date of Birth _____ Place of Birth _____ Citizenship Status _____

Eye Color _____ Hair Color _____ Height Ft _____ In _____ Weight _____

Race _____ Social Security Number _____

Gender Male Female Naturalization Date (if applicable) _____

U.S. Military Service

Yes No

Branch _____ Rank _____ Dates of Service From _____ To _____

Discharge Status _____ Discharge Date _____

Education Information

Starting with high school, list in chronological order all schools, colleges and universities attended, whether completed or not.

Name	City/State	Month/Year From - To	Major/Degree

Examinations

List all nursing examination information below.

Examination	Part/Step	Date of Exam	State	Number of Attempts

Licensure History

List ALL nursing licenses, whether active, inactive or lapsed.

State	Type	License Number	Issue Date	Expiration Date	Status

Practice History

List in chronological order all professional experience. Explain any unaccounted for periods of time exceeding 30 days.

Name	City / State	Month/Year From - To	Position

Explanation _____

National Specialty Certification

National Specialty Board	Specialty	Certification Date

Malpractice / Adverse Actions

Attach details for any affirmative answers.

Has a claim for malpractice ever been made against you, regardless of the outcome? Yes No

Any adverse actions taken against you by a school/university, hospital, nursing board, etc.? Yes No

Been arrested, charged, or convicted of a violation of any local, state, or federal statute? Yes No

Note: Failure to report such events could result in processing delays, fines by the nursing board, or denial of license!

Service Agreement

I, _____ (the undersigned), am hiring you (Medical Licensure Group, LLC) to assist me in applying for state nursing licensure, registrations, and credentials as specified below (the "Services") or as requested from time to time either verbally or in writing by myself, my employer or representatives. I agree to provide you all information and documents required for you to perform the Services, whether directly or via my employer or representatives. I affirm such information is and will be accurate and complete and such documents will be true, correct, and complete copies. I am aware of, and remain responsible for, the deadlines and eligibility requirements for each license, registration, or credential for which I am applying with your assistance. I agree to pay any fees or other charges required or imposed by the licensing boards to file or process my applications for licensure, registration, or credentials that are the subject of the Services. I acknowledge you have no authority to grant or cause to be granted any licensure, registration, or credential and, therefore, you will not be liable to me or any other person regarding the final outcome of my applications for licensure, registration, or credentials. I further acknowledge that you make no guarantee of any timelines in which any license, registration or credential will be granted. I acknowledge I have read and agree to the additional terms and conditions specified at www.MedicalLicensureGroup.com/terms-and-conditions/.

State Licensure Services

Initial License or Reinstatement (\$700/each)

Select this option to obtain licensure in a state for the first time, or if reinstating a previously-held license.

Target State(s) _____

Completion (\$550/each)

Select this option if you would like MLG to handle the completion of an already-filed state application.

Target Completion State(s) _____

Additional Services

Express Processing (\$200/each)

Select this option for accelerated application preparation. Note: State Nursing Boards review applications in date order.

Express State(s) _____

License Maintenance & Renewal (\$225/each)

Select this option to have your currently-active license renewed on a continual basis.

Renewal State(s) _____

By signing below, I have read and agree to the above statement and terms and conditions.

Signature _____ Date _____

Credit Card Authorization

I (the undersigned) authorize you (Medical Licensure Group, LLC) to charge my credit card as payment for your services and for payment of third party charges associated with your services, with all conditions of sale as if I were presenting the credit card to you in person. I represent and warrant to you that I am an authorized cardholder of the credit card, the charges to the credit card will be honored, and I will perform my obligations set forth in the cardholder agreement with the credit card issuer. I acknowledge no funds paid by me to you (by credit card or otherwise) may or will be subject to refund by you to me after you have used those funds to pay third party charges associated with your services performed for me.

Target State(s) _____

Method of Payment

Visa Mastercard American Express Discover

Cardholder Name _____ Expiration Date _____

Card Number _____ Security Number (CCV) _____

Billing Address _____ City, State, Zip _____

Note: A 3% convenience fee will be added to all non-check payments.

By signing below, I have read and agree to the above statement and terms and conditions.

Cardholder Signature _____ Date _____