

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 Names(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 _____

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Education Information

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

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

Examination History

List all nursing examination information below.

Examination	Part/Step	Date of Exam	State	Number of Attempts

Medical Licenses

List ALL states where you hold or have held a license to practice, regardless of the current status.

State	Type	License Number	Issue Date	Expiration Date	Status

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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	Date Certified

Supervising Physician

Provide the requested information for a supervising physician in each state that you are applying to that requires one.
(AL, AR, CA, CT, DE, FL, GA, IL, IN, KS, KY, LA, MI, MS, MO, NE, NJ, NY, NC, NV, OH, OK, PA, SC, TN, TX, UT, VA, WV, WI).

Name	State	License Number	Email/Phone

NURSE SERVICE AGREEMENT

OFFICE USE ONLY _____

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/ea)

State(s) _____

Express Processing (\$200/ea)

Accelerated application preparation

State(s) _____

Note: State Medical Boards review applications in date order

Completion (\$550/ea)

For already-submitted applications

State(s) _____

Additional Services

Independent Practice

Excluded in the following states as these states require a collaborative agreement or do not offer independent practice:
AL, GA, IN, LA, MI, MS, MO, NJ, NC, OH, OK, PA, SC, TN, TX, WV, WI
State(s) _____

Prescriptive Authority

State(s) _____

Controlled Substance Reg. (CSR) (\$125/ea)

AL, CT, DE, DC, HI, ID, IL, IN, IA, LA, MD, MA, MI, MO, NV, NJ, NM, OK, RI, SC, SD, UT, WY

CSR State(s) _____

DEA Registration (\$125/ea)

Initial/New State(s) _____

Modification State(s) _____

Credentialing (\$550/ea)

Number of Applications _____

Other Helpful Services

License Maintenance & Renewal (\$225/ea)

Renewal of currently-active license

RN License Only (\$225/ea)

NP License (Includes RN, if applicable, \$300/ea)

State(s) _____

CSR Renewal (\$125/ea)

State(s) _____

Curriculum Vitae Preparation (\$95)

Portfolio Management (\$550)

Collection and storage of entire professional history

Portfolio Maintenance (\$225/yr)

Documents reviewed/updated annually

DEA Renewal (\$125/ea)

State(s) _____

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

Signature _____ Date: _____