

11. **Attestation**

I declare and affirm that the statements made in the foregoing application are true, complete and correct. Any false or misleading information in, or in connection with my application may be cause for denial of permit and licensure and may result in criminal prosecution.

Applicant's Signature

Date

Section II - Certification of Supervision

Instructions to the Employer:

1. By completing this section, you are certifying that the applicant for the limited permit will be employed under the supervision of a registered professional nurse who is licensed and currently registered in New York State and that you agree to abide by the conditions stipulated on the permit.
2. The applicant must be employed by the facility in which they are working. They may not be employed by a third party.
3. The supervising nurses listed in this section must be Registered Professional Nurses who will work **directly** with the permittee on the same unit so that consistent supervision is ensured.
4. A limited permit expires one year from the date of issuance or upon written notice to the applicant by the Department that the application for licensure has been denied, or 10 days after written notification to the applicant of failure on the professional licensing examination, whichever occurs first. Failing applicants will be advised in writing by the Department to notify their employer of the exam results immediately to allow reasonable notice to the employer that they are no longer able to work under a limited permit.
5. The applicant may not begin practice until the limited permit is issued.*

***EXEMPTION:** New graduates of New York State nursing education programs registered by the New York State Education Department as licensure qualifying **who have applied for licensure and a limited permit** may be employed to practice under the supervision of a registered professional nurse for 90 days immediately following graduation pending receipt of a limited permit. The permittee must submit the employer's copy of the limited permit to the employer as soon as it is received.

1. Permittee's Name _____

2. To be employed as RN LPN

3. Employer (Enter full name - no initials)

Name _____

Address _____
(Street)

_____ City (State/Province) (ZIP Code) (Country)

4. Telephone _____ Fax _____ Email _____

5. If practice site is different from employer's address (item 3), provide that address also

Name _____

Address _____
(Street)

_____ City (State/Province) (ZIP Code) (Country)

_____ (Telephone) (Fax) (Email)

Section II - Certification Supervision (Continued)

6. Supervisor of this permittee

In order to assure that there is always a licensed registered professional nurse available to work directly with this permittee on the specific unit, you must provide the names of two licensed registered professional nurses who will supervise this permittee

1. Supervising registered professional nurse _____

New York State License number _____

2. Supervising registered professional nurse _____

New York State License number _____

7. **Attestation by Director of Nursing or Physician
(To be completed and signed by the director of nursing or designee where the permittee will practice)**

By completing the information in Section II and signing this attestation, I am certifying that the permittee will be employed under the supervision of a registered professional nurse who is licensed and currently registered in New York State, that the supervising nurse will be notified of this responsibility, and that the employer agrees to abide by the conditions stipulated on the permit.

I declare that the statements made in Section II are true, complete and correct. Any false or misleading information in, or in connection with this certification, may be cause for disciplinary action against my license.

Signature on behalf of employer _____
(I.e., Director of Nursing or Physician)

Date _____

Print Name _____

Title _____

New York State Profession _____

New York State Professional License Number _____

If you are applying for an original permit; mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201 U.S.A.. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

If you are ONLY applying for a change of, or additional supervisor/site; mail this form to: New York State Education Department, Office of the Professions, Nurse Unit, 89 Washington Avenue, Albany, NY 12234-1000 U.S.A.. **No fee is needed for this option.**