



## Certified Registered Nurse Anesthetist (CRNA) Information

### License Required

You must hold a current, valid Oregon Certified Registered Nurse Anesthetist license before you practice as a CRNA sign your name, initials or device indicating you are a CRNA. Failure to comply may result in a civil penalty up to \$5,000.

### CRNA Eligibility

- You must have graduated from a nurse anesthesia educational program accredited by an approved accrediting body. Applicants who graduate from an anesthesia program on or after **January 1, 2001** must have a master's degree in anesthesia practice or in a related practice area approved by the Oregon State Board of Nursing (OSBN).
- You must **hold current, unencumbered RN licensure in Oregon**.
- You must meet the practice requirement by:
  - **Graduation from a nurse anesthesia program within the last two years** satisfies the practice requirement, **or**
  - Have **850 hours of CRNA practice within the two years preceding application** for licensure.
- Certification:
  - You must **hold a current certification or recertification from an approved national CRNA certifying body**.
  - If you are a graduate registered nurse anesthetist within nine months of graduation and have not achieved full certification, please call the OSBN office and request an application for CRNA License with Limited Licensure.

Application	Fee	Explanation
CRNA Application	\$150	Required to be certified as a CRNA in Oregon.
Criminal Background Check	\$52	Contact the Board office to obtain a National Criminal Background check packet.

### General Information

- **Oregon uses a biennial birth date renewal system.** Because of this, your first CRNA license may be valid for any length of time between 61 days to two years. Your RN/CRNA will expire midnight before your birthday in odd years if you were born in an odd year or in even years if you were born in an even year.
- You will renew your RN and CRNA licenses **simultaneously**.
- **Fees are non-refundable and processed on receipt.** Even if you do not complete the application process or do not qualify for licensure, the fee is not refundable. The fee pays for processing the application and if you are eligible, issuing the license.
- **Applications are considered based on the date they were postmarked.** If your application is postmarked on or before your expiration date, it is on-time. If it is postmarked **after** the expiration date, it is late and a late fee will be applied.
- Information about nursing practice in Oregon can be found at the **OSBN's web site: [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)**.
- **You or your employer can** visit our website ([www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)) and click "License Verification" to see if your license is active.
- If you have a disability and require special material or assistance, please contact the OSBN office 971-673-0685. If you are hearing impaired, you may reach the OSBN through the Oregon Relay Service, 1-800-735-2900.



## Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road • Portland, OR 97224-7012

Phone: 971-673-0685 • Fax: 971-673-0684 • Website/Verification: [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)

# CRNA Application Checklist

- Complete the **Application for Certified Registered Nurse Anesthetist License**:
  - Don't forget to sign the application.
  - Use your legal name on the application.
- Complete the **Nursing Education History**. For the purpose of this application, provide information about your nurse anesthesia education program on the front of the form and information about your other nursing education on the back of the form.
- Complete the **Nursing Practice History**. Fill out information for at least the most recent two years of your CRNA practice. If you are a current graduate from a CRNA program, include the most recent two years of your Registered Nurse practice.
- Attach a copy of your **current national CRNA certification or recertification**. If you are a recent graduate in the process of your CRNA certification, please contact the OSBN office regarding a Limited CRNA licensure.
- Mail all forms and fee to the OSBN**, Attn: Advanced Practice. Fee for CRNA license is \$150. Please send check or money orders.
- Request that a completed transcript from your CRNA program be mailed to the OSBN**. The transcript must be mailed directly from your nurse anesthesia education program (or from the AANA) to the Oregon State Board of Nursing or received in an envelope secured by the school. The transcript must be imprinted with an official seal, bear the appropriate registrar's signature and must show completion date and degree granted. A **Transcript Request form** is included for your convenience.
- Have a current Oregon RN licensure**. If you do not have a current RN licensure, ensure that the process is completed.
- Contact the Board office to obtain a National Criminal Background Check Packet**.



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# Licensure / Certification General Information

## **Please Note**

If you held an Oregon nursing license / certificate in the past, call the Oregon State Board of Nursing (OSBN) office and ask for information about Reactivation.

## **Application**

- Apply for licensure/certification well in advance of employment in Oregon. In some cases, it can take several weeks for information from schools and other agencies to arrive for processing. If you meet the requirements for licensure/certification, your license will be issued approximately five business days after we have reviewed all of the required information and have determined eligibility.
- The OSBN may deny licensure/certification to an applicant convicted of certain crimes. If you have a criminal history, you will need to report it on your application and attach explanatory information on a separate sheet of paper. Falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of licensure/certification. A positive criminal record check will require investigation and may delay processing. Practicing before you are licensed/certified may result in a civil penalty.
- Your license/certification will be issued using the name on the initial application. If you change your name before or after issue, submit legal documentation of your name change.
- Your mailing address must be complete and current with the board at all times.

## **Fees**

- Fees are non-refundable and processed on receipt. Even if you do not complete the application process or do not qualify for licensure/certification, the fee is not refundable. The fee pays for processing the application and, if you are eligible, issuing the license/certificate.
- A canceled check is your receipt and notification that the OSBN has received the application.

## **Renewal**

- Oregon uses a biennial birth date renewal system. When you receive your license/certificate, please note the expiration date. The expiration date is the midnight before your birthday in an odd year if you were born in an odd year or in an even year if you were born in an even year. Because of this, your first license/certificate may be valid anywhere from 60 days to two years and 59 days depending upon when you were born and when your application is complete. After that, if renewed on schedule, your license/certificate is good for two years.
- Your license is valid until the expiration date noted on the OSBN License Verification system at <http://www.oregon.gov/OSBN>. There is no grace period permitting practice beyond this expiration date.
- You will renew all licenses/certificates simultaneously.
- Notify the OSBN in writing when you change your address to prevent delays in receiving your renewal notice. The post office does not routinely forward the Oregon State Board of Nursing mail.

### **Additional Information**

- Refusal to provide a Social Security Number (SSN) may result in denial of license/certification issuance or renewal. This record of your SSN will be used for child support enforcement, tax administration purposes (including identification) and criminal background checks only, unless you authorize other use. If any disciplinary action is taken against your license/certification, your SSN will be reported to the federal Health Care Integrity and Protection Data Bank. Authority: ORS 25.785, ORS 305.385, USC Section 666 (a)(13).
- If you have a disability that requires special materials or assistance, please contact the OSBN office at 971-673-0685. If you are hearing impaired, you may reach the OSBN through Oregon Relay Service, at 1-800-735-2900.
- Information about nursing practice in Oregon can be found at the OSBN web site at **[www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)**.
- Call the OSBN office 971-673-0685 if you need additional information.
- License/certificate verification is available at <http://www.oregon.gov/OSBN>.



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Application for Certified Registered Nurse Anesthetist License

\$150 non-refundable fee. Please type or print clearly.

\*Use of Social Security Numbers. Under ORS 678.150(4)(7)(a) and (h), the Oregon State Board of Nursing requests that you supply your Social Security Number on this document.

Name: Last First Middle Former/Maiden

Home Address: Street No. City & State Zip Code

Practice Address: Street No. City & State Zip Code

Contact Numbers: Home Work

E-mail Address:

Identification Information: Social Security Number Date of Birth

Current Oregon RN License number:

Expiration Date:

For Office Use Only: Endorsement State or Oregon Graduation Date Application Nursing Practice History \$150 Fee Nursing Education History RN License Current Current Certification Copy # CRNA Transcript Exp Date YES NO discipline

CRNA Approval: Date:

1	Do you have a physical, mental or emotional condition that in any way impairs your ability to perform nursing duties with reasonable skill and safety?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
2	Have you ever been arrested, charged with, entered a plea of guilty, no contest, convicted of or been sentenced for any criminal offense either misdemeanor or felony, including driving under the influence, in any state? (The fact that a conviction has been pardoned, expunged (excluding juvenile record expungement), dismissed or that your civil rights have been restored does not mean that you answer this question "NO"; you would answer "YES" and give details on the charge).	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
3	Have you ever been investigated for any type of abuse in any state?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
4	Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
5	Are any disciplinary actions <u>pending</u> against your nursing license/certificate in any state or US jurisdiction?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
6	Have any disciplinary <u>actions been taken</u> against your nursing license/certificate in any state or US jurisdiction?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
7	Have you ever suffered any civil judgment for incompetence, negligence or malpractice concerning the practice of a health care professional?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
8	Do you use, or have you used in the last five years, chemical substance(s) in any way, which impairs or limits your ability to perform as a nurse with reasonable skill and safety? "Chemical Substance" includes alcohol and drugs.	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
9	Are you currently engaged in the illegal use of controlled substances? (Illegal use of controlled substances means the use of controlled substances obtained illegally (e.g. heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care provider).	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
10	Have you ever been found in any civil, administrative or criminal proceeding to have: a) Possessed, used, prescribed for use or distributed controlled substances or prescription drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or prescription drugs, violated any drug law or prescribed controlled substances for yourself? b) Committed any act involving dishonesty or corruption? c) Violated any state or federal law or rule regulating the practice of a health care profession?	a) <input type="checkbox"/> YES Explain	<input type="checkbox"/> No
		b) <input type="checkbox"/> YES Explain	<input type="checkbox"/> No
		c) <input type="checkbox"/> YES Explain	<input type="checkbox"/> No
11	Have you ever had any certificate, license, registration or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, censured or placed on probation by a state, federal or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
<b>If you answered YES to any of the questions, explain details on a separate sheet.</b>			

Refusal to provide a Social Security Number (SSN) will result in denial of license/certificate issuance or renewal. This record of your SSN will be used for child support enforcement and tax administration purposes (including identification) only, unless you authorize other use. If any disciplinary action is taken against your license/certificate, your SSN will be reported to the federal Health Care Integrity and Protection Data Bank. Authority: ORS 25.785, ORS 305.385, USC § 666(a)(13).

I hereby certify that I am the above named individual and that the information given is true and correct. I am aware that the Oregon State Board of Nursing will conduct a criminal record check through the Law Enforcement Data System (LEDS). I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of license/certification. I voluntarily authorize the Board to submit my Social Security Number to the National Council of State Boards of Nursing for use with the Nurse Information System (NIS), an unduplicated record of all nurses in the United States.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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# CRNA Nursing Practice History Form

- List your CRNA nursing practice history, for the most recent five years in which you practiced nursing.
- Complete a separate section for each nursing position in the last or most recent five years.
- If you volunteered or did private duty, give the name and address of the registry or individual.

You may submit a written explanation of your nursing practice, as long as it contains the same information requested on this form.

Mark here if you are a recent CRNA graduate and do not have CRNA nursing practice history.

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Social Security Number

Indicate your practice hours by calendar year for the most recent six years you have practiced. Do not include hours you were on vacation, sick leave or leave of absence. For example, if you are currently practicing, complete 2002-2007. If you last practiced in 1990, complete 1985-1990. This is the total practice hours by year.

	Year Practiced	Total Hours Practiced	License Type (RN or LPN or CRNA)
1 <sup>st</sup> year			
2 <sup>nd</sup> year			
3 <sup>rd</sup> year			
4 <sup>th</sup> year			
5 <sup>th</sup> year			
6 <sup>th</sup> year			

				( )
Most Recent Employer Name (If none indicate none)		Area Code	Telephone Number	
Practice Address		City	State	Zip Code
<input type="checkbox"/> YES <input type="checkbox"/> NO				
Start Date (MM/DD/YYYY)		Still Employed?	If not Employed, End Date (MM/DD/YYYY)	
<input type="checkbox"/> Paid Nursing Practice		<input type="checkbox"/> Volunteer Nursing Practice		
Position Held (If none indicate none)				
Brief Duties (If none indicate none)				
Brief Duties (If none indicate none)				
Brief Duties (If none indicate none)				

(    )			
Previous Employer Name (If none indicate none)	Area Code	Telephone Number	
Practice Address	City	State	Zip Code
<input type="checkbox"/> YES <input type="checkbox"/> NO			
Start Date (MM/DD/YYYY)	Still Employed?	If not Employed, End Date (MM/DD/YYYY)	
<input type="checkbox"/> Paid Nursing Practice	<input type="checkbox"/> YES	<input type="checkbox"/> Volunteer Nursing Practice	
Position Held (If none indicate none)			
Brief Duties (If none indicate none)			
Brief Duties (If none indicate none)			
Brief Duties (If none indicate none)			

(    )			
Previous Employer Name (If none indicate none)	Area Code	Telephone Number	
Practice Address	City	State	Zip Code
<input type="checkbox"/> YES <input type="checkbox"/> NO			
Start Date (MM/DD/YYYY)	Still Employed?	If not Employed, End Date (MM/DD/YYYY)	
<input type="checkbox"/> Paid Nursing Practice	<input type="checkbox"/> YES	<input type="checkbox"/> Volunteer Nursing Practice	
Position Held (If none indicate none)			
Brief Duties (If none indicate none)			
Brief Duties (If none indicate none)			
Brief Duties (If none indicate none)			

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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# Licensure Transcript Request

**Section I : To be completed by applicant.**

Make as many copies as needed to request transcripts from the schools attended. Most schools require a fee to prepare a transcript. To avoid delays, contact your school(s) and inquire about the fee.

Send this form with Section I completed and the fee to the school.

Applicant Name : \_\_\_\_\_

Mailing Address : \_\_\_\_\_

City, State, and Zip Code : \_\_\_\_\_

Contact Telephone Number : (      ) \_\_\_\_\_

Name on transcript : \_\_\_\_\_

Date of Birth : \_\_\_\_\_

Social Security Number : \_\_\_\_\_

Year of Graduation : \_\_\_\_\_

Degree Attained : \_\_\_\_\_

Signature of Applicant

Date Signed

**Section II : Instructions for the school registrar's office.**

Please attach this Transcript Request to the transcript. The request may contain a current name that is different from the name on the transcript. **The transcript must show the school's official seal, bear the appropriate registrar's signature, degree awarded, and date the degree was awarded.**

Please send official transcripts directly to:

Oregon State Board of Nursing  
17938 SW Upper Boones Ferry Road  
Portland, OR 97224-7012

*Sorry, No Faxes*



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# Nursing Education History

Please type or print clearly using blue or black ink

- Please provide the requested information below for all Nursing education programs completed.
- Please do not attach resume and do not list individual courses taken or continuing education.
- Sealed Nursing transcripts should be delivered directly to the Oregon State Board of Nursing (OSBN) from your school(s). *If you completed Nursing education outside the United States, your credentials evaluation must be provided to the OSBN directly from the credentials evaluation service.*
- **Begin with most recently completed Nursing program and work backwards in time.**

Last Name	First Name	Social Security Number -- --
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School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate	<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor's Degree in Nursing
<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Master's Degree
<input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing
<input type="checkbox"/> Doctorate Degree	<input type="checkbox"/> Doctorate Degree in Nursing
	<input type="checkbox"/> Post-master's Certificate
	<input type="checkbox"/> Other: _____
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	

School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate	<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor's Degree in Nursing
<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Master's Degree
<input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing
<input type="checkbox"/> Doctorate Degree	<input type="checkbox"/> Doctorate Degree in Nursing
	<input type="checkbox"/> Post-master's Certificate
	<input type="checkbox"/> Other: _____
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	

School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Associate Degree <input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Bachelor's Degree in Nursing <input type="checkbox"/> Master's Degree <input type="checkbox"/> Master's Degree in Nursing
<input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Doctorate Degree in Nursing <input type="checkbox"/> Post-master's Certificate <input type="checkbox"/> Other: _____	
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	

School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Associate Degree <input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Bachelor's Degree in Nursing <input type="checkbox"/> Master's Degree <input type="checkbox"/> Master's Degree in Nursing
<input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Doctorate Degree in Nursing <input type="checkbox"/> Post-master's Certificate <input type="checkbox"/> Other: _____	
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	

School Name	City & State (Country)
Degree/Certificate Earned:	
<input type="checkbox"/> LPN/LVN Certificate <input type="checkbox"/> Diploma <input type="checkbox"/> Associate Degree <input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Bachelor's Degree in Nursing <input type="checkbox"/> Master's Degree <input type="checkbox"/> Master's Degree in Nursing
<input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Doctorate Degree in Nursing <input type="checkbox"/> Post-master's Certificate <input type="checkbox"/> Other: _____	
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)
Major	Specialty / Type (if applicable)
Name Listed on Transcript (Your legal name when you attended this school)	

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