

Agenda Item #15.



BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
Board of Vocational Nursing and Psychiatric Technicians
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DATE: August 14, 2015

TO: Board Members

FROM:

Rocio Llamas
Rocio Llamas
Enforcement Program Manager

SUBJECT: Revised Petition for Reinstatement of License Application Form

Attached for review and possible action is a revised Petition for Reinstatement of License Application Form.



PETITION FOR REINSTATEMENT OF LICENSE

(PLEASE TYPE OR PRINT ALL ANSWERS)

NOTE: Pursuant to Government Code section 11522, the Board shall give notice to the Attorney General of the filing of the petition and the Attorney General shall be afforded an opportunity to present oral and written argument before the agency itself.

Name: _____	License Number: _____		
Address: _____ (street, city, state, and zip code)			
Telephone No.: (____) _____			
Date License Was Originally Issued: _____	Date License Was Revoked: _____		
Have You Ever Been Licensed Under Any Other Names(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> Please List: _____ _____			
Will You Be Represented By An Attorney? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name of Attorney: _____	Telephone No: (____) _____		
Address: _____ (street, city, state, and zip code)			
Reason Why License Was Revoked or Surrendered: (Check All Applicable Boxes)			
<input type="checkbox"/> Drug Related	<input type="checkbox"/> Criminal Conviction	<input type="checkbox"/> Gross Negligence	<input type="checkbox"/> Other (Explain Below)
<input type="checkbox"/> Alcohol Related	<input type="checkbox"/> Patient Abuse	<input type="checkbox"/> Incompetence	
Explain Fully The Reason Your License Was Revoked or Surrendered: _____ _____ _____ _____ _____			

Since the date of your revocation or surrender, have you ever been convicted of, pled guilty to, or pled nolo contendere to ANY offense in the United States or a foreign country? Yes No

This includes every citation, infraction, misdemeanor and/or felony, excluding traffic violations under \$1,000 which do not involve alcohol, dangerous drugs or controlled substances. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code Sections 11357(b), (c), (d), (e), or Section 11360(b) which are two years or older should NOT be reported. Convictions that were later dismissed pursuant to section 1203.4, 1203.4a or 1203.41 of the California Penal Code or equivalent non-California law MUST be disclosed. If you have obtained a dismissal of your conviction(s) pursuant to Penal Code sections 1203.4, 1203.41, or 1203.41, please submit a certified copy of the court order dismissing the conviction(s) with your application.

If yes, please provide the violation(s) below.

Date: _____ Violation: _____ Date: _____ Violation: _____
Date: _____ Violation: _____ Date: _____ Violation: _____

Pursuant to Business and Profession Code Sections 2878.7 (e) (VN) and 4524(e) (PT), no petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole or subject to an order of registration pursuant to Section 290 of the Penal Code. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

Since the date of your revocation or surrender, are you subject to an order of registration pursuant to Section 290 of the Penal Code? Yes No

CRIMINAL CONVICTION: (Complete this section if applicable)

Attach Proof of Completion of Probation, Parole or Status of Compliance.

Name of probation/parole officer: _____

Telephone number of probation/parole officer: (_____) _____

Date criminal probation was completed or will be completed: _____

Are you in compliance with the terms and conditions of your criminal probation? Yes No

Explain fully if you are out of compliance with the terms of your criminal probation:

ADDITIONAL LICENSURE:

Do you possess a license and/or certificate to practice nursing or other healthcare related duties in the State of California or any other state? Yes No If yes, please list the state(s) where you are licensed, the license number and the current status of the license.

Name of State	License Number	Type of License	Date of Expiration	Status
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Pursuant to B&P 2878.7(e) and 4524(e), are there any disciplinary actions pending against the above licenses? Yes No

EMPLOYMENT STATUS/HISTORY:

List all employers for the past seven (7) years. Use additional paper if necessary. Provide recent work performance evaluations and/or a letters of recommendation from each of the employers listed below. Provide letters of reference or other documentation addressing your responsibilities, job performance, attendance, attitude, appearance, communication skills, interpersonal skills, etc.

Current Employer:

Employer: _____ Address: _____
(street, city, state, and zip code)

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities:

Reason for Leaving:

#2

Employer: _____ Address: _____
(street, city, state, and zip code)

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities:

Reason for Leaving:

#3

Employer: _____ Address: _____
(street, city, state, and zip code)

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities:

Reason for Leaving:

EDUCATION: Attach Proof of Completion or Attendance/Transcripts

Have you completed or are you currently taking any continuing education courses related to nursing or other healthcare issues? Yes No

List the coursework below:

Coursework Assigned	Name of Provider	Hours/Units	Date Completed

Have you read any books or articles pertaining to your area of professional practice since the date of your revocation? Yes No

If yes, please list the name of the book or periodical in which the article appeared and the name of the Author.

Name of Book/Periodical	Author	Title of Article

If revocation or surrender of your license occurred within the last 4 years, describe your plans for continuing education, if your license is reinstated:

REHABILITATION PROGRAM: (Complete this section if applicable) Attach Proof of Completion of Program and a Description of the Services Provided.

Are you currently attending an alcohol or drug (CHECK ONE or BOTH) rehabilitation program? Yes No

If YES ABOVE, what is the date you entered into the program? _____

If NO ABOVE, have you completed an alcohol/drug rehabilitation program? Yes No

Date entered program: _____ Date completed program: _____

Name of Program: _____ Name of Counselor: _____

Address: _____
(street, city, state, and zip code)

Telephone Number: (_____) _____

Check the type of rehabilitation program: Residential In-patient Out-patient

CHEMICAL DEPENDENCY SUPPORT GROUP: (Complete if Applicable) Attach A Letter From Your Sponsor and/or Others Who Can Testify To Your Attendance, Participation and Rehabilitation Efforts.

What is your sobriety date: _____

Do you currently attend **and** participate in a chemical dependency program, (i.e. Alcoholics Anonymous, Narcotics Anonymous, or a Nurse Support Group):

Yes, currently attending No, attended in the past but no longer No, never attended

State Group Name (as applicable): _____

If NO, please clarify why you no longer attend:

How many meetings per week do (or did) you attend _____

Do you have a sponsor currently? Yes No

Have you abstained from the use of alcohol and/or drugs since your date of sobriety? Yes No

If your answer was no, when was the last time you used drugs or alcohol and what were the circumstances?:

THERAPY: (Complete if applicable) Attach a Letter From Your Psychiatrist, Psychologist or Therapist and/or Group Facilitator Regarding Your Attendance, Participation and Progress.

Name of Doctor/Therapist: _____ Title: _____

Address: _____
(street, city, state, and zip code)

Telephone Number: (____) _____

Are you currently receiving counseling or treatment by a psychologist, psychiatrist, or therapist?
Yes, currently receiving counseling/treatment No, in the past but no longer No, never

If NO, please clarify why:

On average, how often do you attend _____ weekly _____ monthly Not Applicable

Do you currently attend and participate in group therapy?
Yes, currently attending No, in the past but no longer No, never

Name of the group: _____

How often do you attend the group meetings _____ weekly _____ monthly Not Applicable

How has your participation in individual and/or group counseling benefited you?

FITNESS TO PRACTICE IN YOUR LICENSED CAPACITY:

Are you currently under the care of a psychiatrist, physician, dentist, or other healthcare professional for a condition that could impact your skills or abilities as a licensed vocational nurse or psychiatric technician? Yes No

If your answer is yes, what is the reason for your treatment:

Do you have any physical and/or mental disabilities that would preclude you from performing all duties of a licensed vocational nurse or psychiatric technician? Yes No

If your answer is yes, please provide a detailed explanation:

Are you currently taking any prescribed and/or over the counter medication? Yes No

If yes, please list all medications, including dose, and their purpose:

ADDITIONAL INFORMATION: List ANY activities which you have used to prevent a reoccurrence of the violation(s) that led to the revocation or surrender of your license. (Examples: areas of personal growth, continued education not related to your license, exercise programs, voluntary associations, etc.) **Attach Any Documentation To Support Your Response**

HAVE YOU PREVIOUSLY PETITIONED THE BOARD FOR REINSTATEMENT OF YOUR LICENSE?:
Yes No If yes, please provide the attendance dates of the Board Hearings.

This space may be used for answering questions or making additional comments. You may attach extra pages if necessary.

DRAFT