STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov

INSTRUCTIONS TO APPLICANTS FOR LICENSURE AS A PSYCHIATRIC TECHNICIAN

Notice to Individuals (Civil Code, Section 1798.17) -- ALL items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information requested will be used to determine qualifications for examination and/or registration under the Psychiatric Technicians Law. The official responsible for information maintenance is the Executive Officer at the above noted address and telephone number. The information may be transferred to another governmental agency, such as a law enforcement agency, if necessary, for the agency to perform its duties. Individuals have the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by Section 1798.40 of the Civil Code.

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY WHEN COMPLETING YOUR APPLICATION:

STEP #1

APPLICATION FOR PSYCHIATRIC TECHNICIAN EXAMINATION AND LICENSURE – To apply for the Psychiatric Technician examination and licensure you must submit the following:

A. **Application for Psychiatric Technician Licensure** – Complete and sign the Application for Psychiatric Technician Licensure (Form 56A-1).

B. **Social Security Number*** – Business and Professions Code Section 30 and Public Law 94-455 [(42 USCA(c) (2) (C)] authorize collection of your Social Security Number. Applications for licensure will not be processed until a valid U.S. Social Security Number is received.

C. **Photograph** – In a sealed envelope, **include** one 2" X 2" front view, head and shoulders, photograph of yourself. Please **sign** your name on the back of the photograph. This picture **must** be current.

D. **Fingerprints** – See enclosed **"IMPORTANT FINGERPRINT INFORMATION"**. The Board requires a Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) criminal history background check on all applicants. ***A LICENSE WILL NOT BE ISSUED UNTIL THE BOARD RECEIVES THE BACKGROUND INFORMATION FROM DOJ.***

E. **Fee** – Attach a check for $150.00 made payable to the "BVNPT". This is a non-refundable fee that covers the application process. Do **NOT** send cash. **If you will be submitting the hard card fingerprints rather than live scan fingerprints, you must also submit the $49.00 fingerprint processing fees. (See "Important Fingerprint Information" enclosed.)**

F. **Proof of 12th Grade Education** – **Attach** proof of 12th grade education or its equivalent. A copy of your high school diploma **or** GED Certificate is acceptable.

G. **Record of Conviction (55A-6)** – **Complete and sign** the Record of Conviction. Failure to complete this form accurately may delay the processing of your application.

H. **Other Required Documents** – See Step #2 and your specific method of qualifying to ascertain any other documents which **must** be submitted for examination and licensure.

STEP #2

SUMMARY OF REQUIREMENTS FOR LICENSURE *– Read the enclosed Summary of Requirements for Licensure (Form # 56A-9) to determine which method may qualify you for Psychiatric Technician examination and licensure. Follow the instructions below for the method by which you qualify:*

Method #1 – Graduates of California Accredited Psychiatric Technician Schools in California.
Instructions are on file with each school. Applications **must** be submitted by the Director of your program. Contact your Program Director for application instructions.

Method #2 – Equivalent Education and/or Experience.

- **Submit all documentation listed in Step #1.**
- **In addition, you must complete the following procedures:**
  - **Record of Psychiatric Technician Program (or equivalent education) and Official Transcripts (Form 56A-2)** – Send this form to your Psychiatric Technician school (or equivalent education) for completion and request that the school return the completed form to you with an official, certified transcript in a sealed business envelope. ***You must submit the sealed business envelope containing the Record of Psychiatric Technician Program (or equivalent education) and official transcripts with your application for licensure.***
  - **Record of Experience (Form 56A-3)** – Complete this form in full and submit it with your application for licensure.
  - **Employment Verification Form (Form 56A-14)** – Complete Part I of this form. Provide copies to all of the employers that you listed on the Record of Experience (you may reproduce as many copies as needed). The supervisor must complete the remainder of the form and return it to you in a sealed business envelope. ***You must submit the UNOPENED sealed business envelope(s) containing the completed Employment Verification Forms with your application for licensure.***
  - **Proof of 54 Theory Hours of Pharmacology** – Verification of 54 theory hours of pharmacology may be submitted on the Record of Psychiatric Technician Program by the Director of Nursing, **or** a copy of your course completion certificate specifying completion of 54 theory hours of pharmacology **and the grade earned**. ***You must submit the sealed business envelope containing the Record of Psychiatric Technician Program or course completion certificate with your application for licensure.*** (See Summary of Requirements for license (Form 56A-9) for course content requirements.)

Method #3 – Military Applicants.

- **Submit all documentation listed in Step #1.**
- **In addition you must submit:**

A. Transcripts or certificate showing completion of an Armed Forces course involving neuropsychiatric nursing and an Armed Forces or civilian course from an accredited school in the care of the developmentally disabled client.
B. Proof of having completed at least one (1) year of verified full time paid work experience, including:
   1. Military service evaluations verifying at least six (6) months in a military clinical facility caring for clients with mental disorders showing the dates of service; wards assigned and duties performed for each assignment; and
   2. Military or civilian service evaluations verifying at least six (6) months in a military or civilian clinical facility rendering bedside care to clients with developmental disabilities showing the dates of service; wards assigned; and duties performed at each assignment.

IMPORTANT INFORMATION

Address Change

- If you change your address after submitting your application for licensure, you **must** notify the Board in writing immediately, but **no later than thirty (30) days from the date of the address change**.

Application Materials

- The documents you submit **will not** be returned to you.
- The Record of Psychiatric Technician Program must be completed by the Director of your educational program and accompanied by an official certified transcript. The documents must be submitted to the Board with your application in an unopened, sealed business envelope from the school.
- Only official transcripts are acceptable (photocopies are not accepted). Official transcripts must list subjects and hours (theory and clinical) completed and grades received for each subject area. Foreign transcripts must be accompanied by a certified translation if not in English.
- Employment verification forms must be submitted with your application in an unopened, sealed business envelope. Employment verification forms that appear to have been opened and/or altered will not be accepted.

Fees

- The fees for evaluation of your application and processing your fingerprint cards are non-refundable. In addition, please be advised that the fingerprint processing fees are subject to change without notice by the DOJ and FBI. All applicants for licensure by examination are required to attach a check or money order made payable to the "BVNPT" with their application. Please do not send cash.

APPLICATION FOR LICENSURE BY EXAMINATION

Application Fee	$150.00

FINGERPRINT PROCESSING FEES

FBI Fingerprint Card Processing Fee	$17.00
DOJ Fingerprint Card Processing Fee	$32.00
Total Amount Due:	**$49.00****

RETAKE APPLICATION FOR LICENSURE BY EXAMINATION

Application Fee	**$150.00*****

INITIAL LICENSE FEE

When all requirements for licensure have been met, the Board will advise you of the Initial License Fee to be paid. This fee is in addition to the application evaluation fee.

Filing Deadlines

- Applications are accepted on a year-round basis. There are no specific filing deadlines. However, appointments for testing are made on a first-come, first-serve basis.
- You are encouraged to file your application for examination at least three (3) months prior to your anticipated testing date to allow sufficient time for evaluation. **It takes approximately 6 - 8 weeks for processing. You will be notified at that time if additional information is needed to complete the evaluation of your application.**

Name Change

- If you change your name, please notify the Board in writing and attach a copy of one (1) of the following documents: Marriage Certificate, Divorce Decree, Passport, or Driver's License.

Scheduling Your Appointment To Test

- When the Board has processed your application and determined your eligibility, you will be sent a Notice of Eligibility and Candidate Handbook.
- You will be responsible for calling the toll-free telephone number in the Candidate Handbook to schedule an appointment to test. Eligible candidates must test within one (1) year from the date of eligibility indicated on their Notice of Eligibility.

Special Accommodations for Disabled Candidates

- Special testing accommodations are available for candidates with disabilities. Disabled candidates must notify the Board **prior** to scheduling an appointment to test, to obtain the requirements for requesting special accommodations.

*** Disclosure of your Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c) (2) (C))] authorize collection of your Social Security Number. Your Social Security Number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your Social Security Number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board.**

**** The DOJ currently requires live scan fingerprint services to California residents. Applicants submitting live scan fingerprints will be required to pay the fingerprint processing fees at the live scan station. All applicants residing out-of-state must submit hard card fingerprints. If you reside outside of California and will be submitting the hard card fingerprint rather than live scan fingerprints, you must include the $49.00 fingerprint processing fees with your fingerprint cards. The fingerprint processing fees may be combined with the application fee and submitted to the Board on one (1) check or money order, made payable to the "BVNPT". (See "Important Fingerprint Information" enclosed.)**

***** Retake applicants are not required to submit fingerprint cards and the applicable processing fees unless they have not previously satisfied this requirement. Applicants are only required to submit the fingerprint cards and processing fees one (1) time.**

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SUMMARY OF REQUIREMENTS FOR LICENSURE AS A PSYCHIATRIC TECHNICIAN

ALL APPLICANTS FOR LICENSURE AS A PSYCHIATRIC TECHNICIAN IN CALIFORNIA MUST MEET *ALL* OF THE REQUIREMENTS UNDER SECTION A, AND *ONE* OF THE METHODS OF QUALIFYING FOR EXAMINATION IN SECTION B ON PAGE TWO OF THIS DOCUMENT.

SECTION A

1. BE AT LEAST 18 YEARS OF AGE.
2. FURNISH PROOF OF COMPLETION OF THE 12TH GRADE OF SCHOOLING OR ITS EQUIVALENT.
3. COMPLETE AND SIGN THE "APPLICATION FOR PSYCHIATRIC TECHNICIAN LICENSURE" AND FURNISH A VALID U.S. SOCIAL SECURITY NUMBER.
4. COMPLETE AND SIGN THE "RECORD OF CONVICTION" FORM.
5. NOT BE SUBJECT TO DENIAL PURSUANT TO BUSINESS & PROFESSIONS CODE SECTION 480.
6. SUBMIT THE REQUIRED DEPARTMENT OF JUSTICE (DOJ) AND FEDERAL BUREAU OF INVESTIGATION (FBI) FINGERPRINTS.(SEE ENCLOSED "IMPORTANT FINGERPRINT INFORMATION.") ***NOTE: A LICENSE WILL NOT BE ISSUED UNTIL THE BOARD RECEIVES THE BACKGROUND INFORMATION FROM DOJ.***
7. ATTACH THE APPROPRIATE NONREFUNDABLE FEE MADE PAYABLE TO THE "BVNPT" (SEE **FEE SCHEDULE** ON PAGE 3 OF THE ENCLOSED "INSTRUCTIONS TO APPLICANTS FOR LICENSURE AS A PSYCHIATRIC TECHNICIAN)".
8. SUCCESSFULLY COMPLETE A WRITTEN EXAMINATION TITLED THE CALIFORNIA PSYCHIATRIC TECHNICIAN LICENSURE EXAMINATION.
9. SUBMIT THE INITIAL LICENSE FEE. WHEN YOU QUALIFY FOR LICENSURE THE BOARD WILL ADVISE YOU OF THE INITIAL LICENSE FEE TO BE PAID. **THIS FEE IS IN ADDITION TO THE APPLICATION FEE**. IT TAKES 4-6 WEEKS TO PROCESS YOUR LICENSE ONCE THIS FEE HAS BEEN RECEIVED.

SEE BACK SIDE FOR SECTION B OF THE REQUIREMENTS

SECTION B - TO BE DEEMED ELIGIBLE FOR EXAMINATION, YOU MUST QUALIFY BY *ONE* OF THE FOLLOWING METHODS:

1. **GRADUATE OF A CALIFORNIA ACCREDITED SCHOOL FOR PSYCHIATRIC TECHNICIANS.**

   SUCCESSFUL COMPLETION OF A CALIFORNIA **ACCREDITED** PSYCHIATRIC TECHNICIAN PROGRAM.

2. **EQUIVALENT STUDY AND TRAINING (NON-MILITARY)**.
   COMPLETION OF 576 HOURS OF THEORY (EXPERIENCE MAY NOT BE SUBSTITUTED FOR FORMAL COURSE WORK) AND 954 HOURS OF SUPERVISED CLINICAL EXPERIENCE WITHIN TEN YEARS PRIOR TO THE DATE OF APPLICATION. THE FOLLOWING MINIMUM HOURS SHALL BE INCLUDED:

   A. PHARMACOLOGY COURSE (54 THEORY HOURS)
      - KNOWLEDGE OF COMMONLY USED DRUGS AND THEIR ACTIONS
      - COMPUTATION OF DOSAGES
      - PREPARATION OF MEDICATIONS
      - PRINCIPLES OF ADMINISTRATION

   B. 126 HOURS OF THEORY (EXPERIENCE MAY NOT BE SUBSTITUTED FOR FORMAL COURSE WORK) AND 270 HOURS OF SUPERVISED CLINICAL EXPERIENCE IN NURSING SCIENCE, COVERING THE CONTENT IN TITLE 16, CALIFORNIA CODE OF REGULATIONS SECTION 2587(d)(7) AND INCLUDING VERBAL AND WRITTEN COMMUNICATION SKILLS. YOU MAY SUBSTITUTE PAID INPATIENT BEDSIDE WORK EXPERIENCE IN NURSING SCIENCES FOR THE 270 HOURS OF SUPERVISED CLINICAL EXPERIENCE.

   C. 108 HOURS OF THEORY (EXPERIENCE MAY NOT BE SUBSTITUTED FOR FORMAL COURSE WORK) AND 270 HOURS OF SUPERVISED CLINICAL EXPERIENCE IN MENTAL DISORDERS, COVERING THE CONTENT IN TITLE 16, CALIFORNIA CODE OF REGULATIONS SECTION 2587(d)(11) AND INCLUDING VERBAL AND WRITTEN COMMUNICATION SKILLS. YOU MAY SUBSTITUTE PAID INPATIENT BEDSIDE WORK EXPERIENCE IN MENTAL DISORDERS FOR THE 270 HOURS OF SUPERVISED CLINICAL EXPERIENCE.

   D. 108 HOURS OF THEORY (EXPERIENCE MAY NOT BE SUBSTITUTED FOR FORMAL COURSE WORK) AND 270 HOURS OF SUPERVISED CLINICAL EXPERIENCE IN DEVELOPMENTAL DISABILITIES, COVERING THE CONTENT IN TITLE 16, CALIFORNIA CODE OF REGULATIONS SECTION 2587(D)(10) AND INCLUDING VERBAL AND WRITTEN COMMUNICATION SKILLS. YOU MAY SUBSTITUTE PAID INPATIENT BEDSIDE WORK EXPERIENCE IN DEVELOPMENTAL DISABILITIES FOR THE 270 HOURS OF SUPERVISED CLINICAL EXPERIENCE.

   ANY OR ALL OF THE SUPERVISED CLINICAL EXPERIENCE MAY BE SATISFIED BY PAID INPATIENT BEDSIDE WORK EXPERIENCE. PAID INPATIENT BEDSIDE WORK EXPERIENCE IS THE PERFORMANCE OF DIRECT PATIENT CARE FUNCTIONS PROVIDED THROUGHOUT THE PATIENT'S STAY THAT ENCOMPASSES THE BREADTH AND DEPTH OF EXPERIENCE EQUIVALENT TO THAT PERFORMED BY THE PSYCHIATRIC TECHNICIAN.

3. **NURSING SERVICE IN THE MEDICAL CORPS OF ANY BRANCH OF THE ARMED FORCES OF THE UNITED STATES. THIS METHOD REQUIRES**:

   A. COMPLETION OF AN ARMED FORCES COURSE INVOLVING NEUROPSYCHIATRIC NURSING; **AND**

   B. COMPLETION OF AN ARMED FORCES OR CIVILIAN COURSE FROM AN ACCREDITED SCHOOL IN THE CARE OF THE DEVELOPMENTALLY DISABLED CLIENT; **AND**

   C. COMPLETION OF ONE YEAR OF VERIFIED FULL TIME WORK EXPERIENCE, INCLUDING:
      - AT LEAST SIX MONTHS IN A MILITARY CLINICAL FACILITY CARING FOR CLIENTS WITH MENTAL DISORDERS; **AND**
      - AT LEAST SIX MONTHS IN A MILITARY OR CIVILIAN CLINICAL FACILITY CARING FOR CLIENTS WITH DEVELOPMENTAL DISABLITIES.
      - MILITARY OR CIVILIAN SERVICE EVALUATIONS SHOWING THE DATES OF SERVICES, WARDS ASSIGNED AND DUTIES PERFORMED FOR EACH ASSIGNMENT MUST BE SUBMITTED IN ORDER TO VERIFY THE REQUIRED EXPERIENCE.

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APPLICATION FOR PSYCHIATRIC TECHNICIAN LICENSURE

DO NOT WRITE IN THIS SPACE
APP. NO
LIC. NO
ILF-CA NO.
ATS NO.

(ATTACH $150 APPLICATION FEE. AN ADDITIONAL $49 FINGERPRINT FEE IS REQUIRED FOR PROCESSING HARD CARD FINGERPRINTS – SEE ENCLOSED INSTRUCTIONS.)

Read all the enclosed instructions carefully before completing this application. This information is required under Business and Professions Code Division 2, Chapter 10, Articles 1 and 2. The information you furnish will be used to determine your eligibility for licensure. If additional space is needed to complete any section of this application, please attach additional sheets. The Executive Officer of the Board is responsible for information maintenance.

PRINT OR TYPE (DO NOT USE PENCIL)

1. NAME (LAST) (FIRST) (MIDDLE)

2. ADDRESS (STREET OR BOX NUMBER) (APT. NO)

3. CITY STATE ZIP

4. BIRTHDATE (Month/Day/Year)

5. SOCIAL SECURITY NUMBER*

6. TELEPHONE NUMBER
Business (____)_____
Home (_____)_____
Area Code

7. DID YOU GRADUATE FROM HIGH SCHOOL? ☐YES ☐NO NAME OF HIGH SCHOOL:_____ CITY/STATE:_____

DID YOU PASS A HIGH SCHOOL EQUIVALENCY TEST? ☐YES ☐NO If NO, CIRCLE THE HIGHEST GRADE YOU COMPLETED 1 2 3 4 5 6 7 8 9 10 11 12

8. DID YOU ATTEND A PSYCHIATRIC TECHNICIAN PROGRAM? ☐YES ☐NO DID YOU GRADUATE FROM THE PROGRAM? ☐YES ☐NO
IF YES, NAME OF PSYCHIATRIC TECHNICIAN PROGRAM: DATE STARTED: DATE COMPLETED: STATE OR COUNTRY:
_____ _____ _____ _____

9. DID YOU ATTEND ANY OTHER COLLEGE OR UNIVERSITY PROGRAM? ☐YES ☐NO DID YOU GRADUATE FROM THE PROGRAM? ☐YES ☐NO
IF YES, NAME OF PROGRAM: DATE STARTED: DATE COMPLETED: STATE OR COUNTRY:
_____ _____ _____ _____

10. HAVE YOU EVER BEEN LICENSED AS A PSYCHIATRIC TECHNICIAN? ☐YES ☐NO DATE LICENSED:_____ STATE OF "ORIGINAL" LICENSE:_____

IF YES, HAS THIS LICENSE EVER BEEN SUSPENDED, REVOKED OR PLACED ON PROBATION? ☐YES ☐NO (*IF YES, ATTACH EXPLANATION*)

11. HAVE YOU EVER BEEN LICENSED AS A VOCATIONAL/PRACTICAL NURSE? ☐YES ☐NO DATE LICENSED:_____STATE OF "ORIGINAL" LICENSE:_____

IF YES, HAS THIS LICENSE EVER BEEN SUSPENDED, REVOKED OR PLACED ON PROBATION? ☐YES ☐NO (*IF YES, ATTACH EXPLANATION*)

12. HAVE YOU EVER APPLIED TO THIS BOARD FOR LICENSURE UNDER A DIFFERENT NAME? ☐YES ☐NO
IF YES, PLEASE LIST OTHER NAMES:

WILL DOCUMENTS BE SUBMITTED TO THIS BOARD UNDER A DIFFERENT NAME? ☐YES ☐NO
IF YES, PLEASE LIST OTHER NAMES:

13. **CONFIDENTIALITY NOTICE:** YOU ARE ADVISED THAT PURSUANT TO BUSINESS AND PROFESSIONS CODE, SECTION 123, THE CONTENT OF THE PSYCHIATRIC TECHNICIAN LICENSURE EXAMINATION IS CONFIDENTIAL. IF YOU ARE DEEMED ELIGIBLE TO TAKE THIS EXAMINATION, YOU ARE HEREBY NOTIFIED THAT UNAUTHORIZED POSSESSION, REPRODUCTION, OR DISCLOSURE OF ANY EXAMINATION MATERIALS IS IN VIOLATION OF THE LAW AND SUBJECT TO CRIMINAL MISDEMEANOR PROSECUTION. A VIOLATION OF THIS TYPE MAY ALSO RESULT IN CIVIL LIABILITY AND/OR DISCIPLINE BY THE LICENSING AGENCY INCLUDING THE DENIAL OF LICENSURE.

14. **PHOTOGRAPH REQUIREMENTS:** YOU MUST ATTACH A CURRENT, FRONT VIEW, HEAD AND SHOULDER PHOTOGRAPH OF YOURSELF IN A SEALED ENVELOPE. THE PHOTOGRAPH SHOULD BE 2" X 2" AND MUST BE SIGNED ON THE BACK.

15. **PLEASE READ CAREFULLY BEFORE SIGNING**. *– I hereby certify, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct. False statements included in this application can result in licensure denial.*

SIGNATURE:_____ DATE:_____

SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT –
Disclosure of your Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c) (2) (C))] authorizes collection of your Social Security Number. Your Social Security Number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your Social Security Number, your application for initial licensure will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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RECORD OF PSYCHIATRIC TECHNICIAN PROGRAM (OR EQUIVALENT EDUCATION)

The applicant should complete the first section of this form and provide it to the Director of the psychiatric technician program. The Director of the psychiatric technician program should complete the information in the second section and return it to the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT (ITEMS 1-6). PRINT OR TYPE (DO NOT USE PENCIL).

1. NAME (LAST)	(FIRST)	(MIDDLE)
2. ADDRESS	(STREET OR BOX NUMBER)	(APT. NO)
3. CITY	STATE	ZIP
4. BIRTHDATE (Month/Day/Year)	5. SOCIAL SECURITY NUMBER*	6. TELEPHONE NUMBERS Business ( )_____ Home ( )_____ Area Code

THIS SECTION TO BE COMPLETED BY PSYCHIATRIC TECHNICIAN SCHOOLS, OR SCHOOLS OF VOCATIONAL, PRACTICAL OR REGISTERED NURSING. PRINT OR TYPE (DO NOT USE PENCIL).

7. NAME OF PSYCHIATRIC TECHNICIAN PROGRAM CITY STATE

_____ _____

DATE PROGRAM STARTED:_____DATE PROGRAM COMPLETED:_____OR DATE VERIFIED HOURS WERE COMPLETED_____

WAS PROGRAM "ACCREDITED" WHEN HOURS WERE COMPLETED? ☐ YES ☐NO

8. NAME OF SCHOOL OF VOCATIONAL OR PRACTICAL OR REGISTERED NURSING? CITY STATE

_____ _____

DATE PROGRAM STARTED:_____DATE PROGRAM COMPLETED:_____OR DATE VERIFIED HOURS WERE COMPLETED_____

WAS PROGRAM "ACCREDITED" WHEN HOURS WERE COMPLETED? ☐YES ☐NO

9. COMPLETION OF THE TWELFTH (12TH) GRADE IN HIGH SCHOOL OR ITS EQUIVALENT HAS BEEN PROVEN BY THE APPLICANT AS FOLLOWS:

☐ PRESENTED OFFICIAL SCHOOL RECORDS SHOWING COMPLETION OF 12TH GRADE HIGH SCHOOL

☐ PASSED THE "GED" TEST AT THE 12TH GRADE LEVEL

10. A. TOTAL NUMBER OF THEORY/CLINICAL HOURS COMPLETED IN ***YOUR*** PSYCHIATRIC TECHNICIAN PROGRAM:

THEORY:_____HOURS CLINICAL:_____HOURS

B. TOTAL NUMBER OF THEORY/CLINICAL HOURS WHICH YOUR SCHOOL GRANTED CREDIT FOR "PREVIOUS EDUCATION":

THEORY:_____HOURS CLINICAL:_____HOURS

C. ***COMPLETE THE SECOND PAGE OF THIS FORM IN FULL. THIS IS A MANDATORY REQUIREMENT.***

11. *I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.*

SIGNATURE OF PROGRAM DIRECTOR:_____

(SCHOOL SEAL)

PRINT PROGRAM DIRECTOR'S NAME:_____

DATE:_____

SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT –
Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c)(2)(C))] authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board.

RECORD OF PSYCHIATRIC TECHNICIAN PROGRAM (OR EQUIVALENT EDUCATION)

THE SECTION OF THIS FORM MUST BE COMPLETED IN FULL.

1. NAME OF SCHOOL OF NURSING CHECK ONE: ☐PSYCHIATRIC TECHNICIAN PROGRAM ☐VOCATIONAL/PRACTICAL NURSING OR REGISTERED NURSING PROGRAM	2. CITY	3. STATE AND COUNTRY
4. DATE PROGRAM STARTED: _____ (MONTH/DAY/YEAR)	5. DATE VERIFIED HOURS WERE COMPLETED: _____ (MONTH/DAY/YEAR)	

6. SUBJECT	ACTUAL HOURS/UNITS COMPLETED		CHECK HERE IF SUBJECT IS INTEGRATED	GRADE RECEIVED		HOURS/UNITS OF CREDIT GRANTED FOR PREVIOUS LEARNING	
	THEORY	CLINICAL		THEORY	CLINICAL	THEORY	CLINICAL
ANATOMY & PHYSIOLOGY		N/A			N/A		N/A
NUTRITION		N/A			N/A		N/A
PSYCHOLOGY		N/A			N/A		N/A
NORMAL GROWTH & DEVELOPMENT		N/A			N/A		N/A
PHARMACOLOGY		N/A			N/A		N/A
COMMUNICATION		N/A			N/A		N/A
NURSING SCIENCE, WHICH INCLUDES: A) NURSING FUNDAMENTALS, B) MEDICAL/SURGICAL NURSING, C) COMMUNICABLE DISEASES, INCLUDING HIV, AND D) GERONTOLOGICAL NURSING							
NURSING PROCESS							
DEVELOPMENTAL DISABILITIES							
MENTAL DISORDERS							
PATIENT EDUCATION		N/A			N/A		N/A
LEADERSHIP		N/A			N/A		N/A
SUPERVISION		N/A			N/A		N/A
ETHICS AND UNETHICAL CONDUCT		N/A			N/A		N/A
CRITICAL THINKING		N/A			N/A		N/A
CULTURALLY CONGRUENT CARE							
END-OF-LIFE CARE							
TOTAL HOURS:							

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RECORD OF EXPERIENCE

PRINT OR TYPE (DO NOT USE PENCIL).

1. NAME (LAST)	(FIRST)	(MIDDLE)
2. ADDRESS	(STREET OR BOX NUMBER)	(APT. NO)
3. CITY	STATE	ZIP
4. BIRTHDATE (Month/Day/Year)	5. SOCIAL SECURITY NUMBER*	6. TELEPHONE NUMBERS BUSINESS ( )_____ HOME ( )_____ AREA CODE

EXPERIENCE: List your experience record for the past ten (10) for which you will be submitting verification of employment. It is your responsibility to contact each employer and provide them with a copy of the Employment Verification form for completion.

7A. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	*THIS SPACE FOR OFFICE USE ONLY*
7B. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	
7C. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	

PLEASE READ CAREFULLY BEFORE SIGNING. *– I hereby certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. False statements included in this application can result in licensure denial.*

SIGNATURE:_____ DATE:_____

7D. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	*THIS SPACE FOR OFFICE USE ONLY*
7E. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	
7F. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	
7G. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	
7H. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	

*** SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT –**

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c)(2)(C))] authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov

EMPLOYMENT VERIFICATION FORM

INSTRUCTIONS TO APPLICANT:

- Complete Part I on the second page of this form and provide a copy of both pages to each employer for the past ten (10) years. (You may reproduce as many copies of this form as needed.)

- This form must be completed in full by the Supervisor and ***returned directly to you in the employer's sealed business envelope. The UNOPENED sealed envelopes containing the Employment Verification Forms must be submitted to the Board with your Application for Psychiatric Technician Licensure.***

- If you already have an application on the file with the Board and are submitting additional experience, the employment verification form may be submitted to the Board by the applicant or the employer, but must be received in the employer's sealed business envelope.

Please be advised that employment verification forms that appear to have been opened or altered will not be accepted. The Board conducts random audits to verify the accuracy of the information submitted. Discrepancies or false statements included in the application can result in licensure denial.

INSTRUCTIONS TO EMPLOYER:

The applicant on page two of this form is applying for licensure as a psychiatric technician under Section 4511 of the Business and Professions Code. In order for the applicant to receive credit for paid work experience, State law requires the Board to obtain verification of employment from the Supervisor.

- Please complete Parts II and III on page two of this form and ***return it to the applicant in a sealed business envelope.*** Indicate on the outside of the envelope ***"Employment Verification Enclosed – Do Not Open"***. It is the applicant's responsibility to collect the Employment Verification Form(s) and submit them with the application for licensure.

- **Part II:** Indicate the name and type of facility where the experience was obtained.

- **Part III:** Provide the specific dates that the applicant worked under your supervision, in the area being verified. Additionally, indicate if the applicant was employed full time (40 hrs./wk.) or part time and include the number of hours worked in each area. The Board MUST receive a breakdown of the number of hours spent in each area, in order to evaluate the experience.

Thank you for your assistance. Please feel free to contact the Board at (916) 263-7830 if you have any questions.

BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS

EMPLOYMENT VERIFICATION FORM

Part I is to be completed by the applicant and submitted to employers for verification of work experience. The remainder of this form must be completed by the Supervisor and returned to the applicant by the employer in a sealed business envelope. FORMS CONTAINING STRIKEOUTS OR CORRECTIONS WILL NOT BE ACCEPTED. (See Page 1 for detailed instructions on how to complete this form.)

Part I: To be completed by the Applicant (print or type - do not use pencil):

1. NAME (LAST)	(FIRST)	(MIDDLE)
2. ADDRESS	(STREET OR BOX NUMBER)	(APT. NO)
3. CITY	STATE	ZIP
4. NAME WHILE EMPLOYED AT THIS FACILITY:	5. SOCIAL SECURITY NUMBER* **NOT required, but may assist employer in locating records*	6. DAYTIME TELEPHONE NUMBER ( ) _____ Area Code

Part II: To be completed by the Employer - Indicate the name and type of facility where the experience was obtained:

Name of facility where experience was obtained:

Medical-Surgical Nursing Science Clinical Experience - Type of Facility:
□ Acute or sub-acute(hospital) □ Assisted Living □ Convalescent □ Home Health □ Outpatient Clinic/Emergency Care
□ Skilled Nursing/Long Term Care □ Other:

Mental Disorders Clinical Experience - Type of Facility:
□ Acute Psychiatric Hospital □ Correctional Facility □ Long Term Psychiatric Facility □ Mental Health Clinic
□ Substance Abuse Unit □ Residential Care Facility □ Other:

Developmental Disabilities Clinical Experience - Type of Facility:
□ Day Treatment Center □ Private Developmental Center □ Rehabilitation Center □ Residential Care Home
□ State Developmental Center □ Other:

Part III: To be completed by the Employer - Include dates and the area of nursing being verified. Indicate if employment was full-time (40 hrs/wk) or part-time and include the total number of hours worked in each area:

Areas of Paid Work Experience	Employment Period: (Month/Date/Year)	Hours Worked Per Week	Total Hours In Each Area	For Office Use Only
Mental Disorders	From: / / To: / /			
Developmental Disabilities	From: / / To: / /			
Medical-Surgical Nursing	From: / / To: / /			
Other:	From: / / To: / /			

TO BE SIGNED BY THE SUPERVISOR:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.

Signature: _____ Print Name_____
License # _____ Exp. Date:_____ Telephone Number: (_____)_____
Address: _____ Today's Date: _____
City/State: _____ Zip Code:_____

BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
RECORD OF CONVICTION

TYPE OR PRINT (USE BLUE OR BLACK INK ONLY). IF MORE SPACE IS NEEDED TO COMPLETE ANY SECTION, PLEASE ATTACH ADDITIONAL SHEETS.

1. NAME (LAST)	(FIRST)	(MIDDLE)
2. ADDRESS (STREET OR BOX NUMBER)		(APARTMENT NUMBER)
3. CITY	STATE	ZIP

4. BIRTHDATE (MM/DD/YYYY)	6. TELEPHONE NUMBERS CELL (_____) _____ HOME (_____) _____ BUSINESS (_____) _____
5. SOCIAL SECURITY OR INDIVIDUAL TAXPAYER IDENTIFICATION NUMBER	

7. Pursuant to Business and Professions Code Section 480 (c), any false statements included in this application may result in license denial. Please carefully read all information contained on the front and back of this form before signing. **I declare under penalty of perjury under the laws of the State of California that the information provided herein and attachments is true and correct.**

Signature: _____ Date: _____

8. Are you or have you previously been licensed or certified as a psychiatric technician, practical, vocational or registered nurse, or any other healthcare professional in this or any other state, territory or country?	☐ Yes ☐ No

A.	State	License Type	License #	Expiration Date #
		☐ PT ☐ LVN/LPN ☐ RN ☐ Other (specify) _____		
		☐ PT ☐ LVN/LPN ☐ RN ☐ Other (specify) _____		
		☐ PT ☐ LVN/LPN ☐ RN ☐ Other (specify) _____		

B. Has your license or certification ever been suspended, revoked, placed on probation or disciplined? *If Yes, you must explain the basis for the disciplinary action and submit a copy of the disciplinary order*.	☐ Yes ☐ No
C. Have you used any other names? If Yes, list all other names used: _____	☐ Yes ☐ No
9. Have you ever been convicted of, pled guilty to, or pled nolo contendere to ANY offense in the United States or a foreign country? *If YES, you must, complete item 12 on the back of this form.* 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, 1203.4(a), or 1203.41, please submit a certified copy of the court order dismissing the conviction(s) with your application.	☐ Yes ☐ No
10. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions two years or older under California Health and Safety Code Sections 11357(b), (c), (d), (e) or section 11360(b), have you had a conviction that was set aside or later expunged from the records of the court? *If YES, you must, complete item 12 on the back of this form.*	☐ Yes ☐ No
11. Is any court action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict? *If YES, you must, complete item 12 on the back of this form.*	☐ Yes ☐ No

- CONTINUED ON REVERSE -

12. If you answered yes to item 9, 10, or 11, you must provide all of the information requested below for each offense. Department of Motor Vehicles printouts are not accepted in lieu of completing this section. If more space is needed to complete this section, please attach additional sheets.

If you have been convicted of a crime, you must submit certified court documents, police reports, and a detailed explanation, in your own words, for each offense. (Certified court/police documents are obtained directly from the court/police department with an **original** stamp of certification. Do not send copies, as they will not contain an original certification and will not meet the requirement for certified documents. If the police report and/or court documents are no longer available, you must obtain a statement from the police department or court attesting to that fact.) **Additionally, please submit documents regarding your rehabilitation efforts, such as:**

- Proof that you complied with the terms of your parole, probation, restitution or any other court imposed sanctions.
- Evidence of expungement proceedings pursuant to penal code section 1203.4, 1203.4(a), or 1203.41.
- Any other evidence of rehabilitation you wish the board to consider.

A. Date of Offense _____ B. City and State of Offense _____

C. Name and location of court where your case was heard _____

D. Details of the offense of which you were convicted _____

_____

E. Date of Conviction _____ F. Date(s) of Imprisonment, if applicable _____

G. Amount of fine paid _____ H. Period of Probation _____

I. Conditions of Probation _____

_____

_____

A. Date of Offense _____ B. City and State of Offense _____

C. Name and location of court where your case was heard _____

D. Details of the offense of which you were convicted _____

_____

E. Date of Conviction _____ F. Date(s) of Imprisonment, if applicable _____

G. Amount of fine paid _____ H. Period of Probation _____

I. Conditions of Probation _____

_____

_____

A. Date of Offense _____ B. City and State of Offense _____

C. Name and location of court where your case was heard _____

D. Details of the offense of which you were convicted _____

_____

E. Date of Conviction _____ F. Date(s) of Imprisonment, if applicable _____

G. Amount of fine paid _____ H. Period of Probation _____

I. Conditions of Probation _____

_____

_____

Important note: You will be permitted to take the licensing examination regardless of any criminal conviction history you disclose. However, a determination as to whether your license will be granted or denied will not be made until you have passed the examination and the board has received all required conviction documentation.

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Notice on Collection of Personal Information For Applicants and Licensees

Collection and Use of Personal Information. The Board of Vocational Nursing and Psychiatric Technicians (BVNPT) of the Department of Consumer Affairs (DCA) collects the personal information requested on this form as authorized by Business and Professions Code Section 30 (General Provisions); Business and Professions Code Division 2, Chapter 6.5, Articles 1 & 2 (Vocational Nursing Practice Act) and Chapter 10, Articles 1 & 2 (Psychiatric Technicians Law); and California Code of Regulations Title 16, Division 25, Chapter 1 (Vocational Nurses) and Chapter 2 (Psychiatric Technicians). The BVNPT uses this information principally to identify and evaluate applicants for licensure, issue and renew licenses, and enforce licensing standards set by law and regulation.

Mandatory Submission. Submission of the requested information is mandatory. The BVNPT cannot consider your application for licensure or renewal unless you provide all of the requested information.

Access to Personal Information. You may review the records maintained by the BVNPT that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. The BVNPT makes every effort to protect the personal information you provide. The information you provide, however, may be disclosed in the following circumstances:

- In response to a Public Records Act request (Government Code Section 6250 and following), as allowed by the Information Practices Act (Civil Code Section 1798 and following);
- To another government agency as required or permitted by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

Contact Information. For questions about this notice or access to your records, you may contact the BVNPT at 2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833, (916) 263-7800 or email bvnpt@dca.ca.gov.

55P-1 (4/21/09)