FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
ID#:
Receipt #:

Center for Professional Licensing

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Emergency 90 Day Temporary License By Reciprocity

- ☐ Chiropractor/Physiotherapy
- ☐ Mental Health Counselor
- ☐ Practical Nurse ☐ Registered Nurse
- ☐ Nursing Assistant
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Volunteer Allopathic Physician
- ☐ Osteopathic Physician
- ☐ Physician Assistant
- ☐ Nuclear Medicine Technologist
- ☐ Radiographer
- ☐ Emergency Medical Responder
- ☐ Advanced Emergency Medical Technician
- ☐ Advanced Emergency Medical Technician - Cardiac
- ☐ Dietitian/Nutritionist
- ☐ Naturopathic Physician
- ☐ APRN Focus________________________
- ☐ Medication Aide
- ☐ Pharmacist
- ☐ Allopathic Physician
- ☐ Limited Physician
- ☐ Volunteer Osteopathic Physician
- ☐ Psychologist
- ☐ Radiation Therapist
- ☐ Respiratory Care Practitioner
- ☐ Emergency Medical Technician
- ☐ Paramedic

Applicant - Print Name

LAST NAME	***FIRST NAME***	***MI***

Phone: (401) 222-2828 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

Licensure Information

As part of our response to coronavirus disease 2019 (COVID-19), the Rhode Island Department of Health will be relaxing regulatory enforcement for certain medical professional licensing by issuing temporary (90 day) licenses to professionals holding valid out-of-state licenses.

Beginning March 18, 2020 out-of-state licensees need only submit a completed application form and a statement verifying the license status from their home state to receive a 90-day license to practice in Rhode Island. This temporary license can be renewed one time. There will be no cost to obtain the license or for the one-time renewal. Professionals who wish to practice beyond the 180 days must fulfill all qualifications and requirements under the regulations for their profession.

For questions regarding this license please email doh.elicense@health.ri.gov

Mail to:

Center for Professional Licensing
Room 104
3 Capitol Hill
Providence, RI 02908-5097

State of Rhode Island and Providence Plantations
Emergency 90 Day Temporary License By Reciprocity

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

NOTE:
It is your responsibility to notify the Department of Health Board of any name changes.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden Name, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

____

2. Social Security Number

___ – __ – ____
U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify the board of all address changes.

No professional licensee's address (residence or business/employment) will be posted on the Department's Web site.

1st Line Address (Apartment/Suite/Room Number, etc.)

2nd Line Address (Number and Street)

City State Zip Code –

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone – Home Fax –

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code –

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone – Extension Business Fax –

Applicant: Print your complete last name >

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

NOTE: The preferred mailing address that you indicate is the address that will be released for all requests for that information.

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Type of School (University, College, Technical School, etc.)

Name of School

Date Graduated Month Year

Degree Received:

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, enter all other state licenses in Question 10 (below):

10. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession*.

State/Country:			State/Country:		
________	☐ Active	☐ Inactive	________	☐ Active	☐ Inactive
________	☐ Active	☐ Inactive	________	☐ Active	☐ Inactive
________	☐ Active	☐ Inactive	________	☐ Active	☐ Inactive

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year
________		
________		
________		

12. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

13. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, ____________________________________, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this affidavit is signed.

______________________________ Signature of Applicant

______________________________ Date of Signature (MM/DD/YY)