

Michigan Department of Community Health

**Board of Nursing**

P.O. Box 30193

Lansing, Michigan 48909

(517) 335-0918

[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)

**NURSE SPECIALTY CERTIFICATION INSTRUCTIONS**

Authority: P.A. 368 of 1978, as amended  
This form is for information only.

**NOTE:** It is your responsibility to have all required documentation sent to the Board of Nursing. Questions regarding your application can be directed to the Michigan Board of Nursing at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

**GENERAL INSTRUCTIONS:**

1. The Michigan Board of Nursing may issue a nurse specialty certification to a currently licensed Michigan registered nurse if the applicant meets the state certification requirements.
2. Complete the Application for Nurse Specialty Certification and submit it along with the appropriate fee to the Board office. The check or money order must be drawn on a U.S. financial Institution and made payable to the **STATE OF MICHIGAN**. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
3. Provide verification that you meet the requirements for Michigan Nurse Specialty Certification as indicated below:

**NURSE ANESTHETIST SPECIALTY CERTIFICATION** - You must hold a current Michigan R.N. license in addition to the following:

- A. Complete Section I of the Nurse Anesthetist Specialty Certification form.
- B. Forward the Nurse Anesthetist Specialty Certification form to the American Association of Nurse Anesthetists Council on Certification or Council on Recertification of Nurse Anesthetists for completion of Section II verifying your current certification. **This completed Nurse Anesthetist Specialty Certification form must be received by the Michigan Board of Nursing office DIRECTLY FROM your certifying agency.**

**NURSE MIDWIFE SPECIALTY CERTIFICATION** - You must hold a current Michigan R.N. license in addition to the following:

- A. Complete Section I of the Nurse Midwife Specialty Certification form.
- B. Forward the Nurse Midwife Specialty Certification form to the American Midwifery Certification Board (formerly ACNM Certification Council) for completion of Section II verifying your current certification. **This completed Nurse Midwife Specialty Certification form must be received by the Michigan Board of Nursing office DIRECTLY FROM your certifying agency.**

**NURSE PRACTITIONER SPECIALTY CERTIFICATION** - You must hold a current Michigan R.N. license and have a Bachelor of Science degree, or higher degree, in nursing, in addition to the following:

- A. Complete Section I of the Nurse Practitioner Specialty Certification form and forward it to the appropriate agency that can verify you hold certification from one of the following certification organizations:

**AMERICAN NURSES CREDENTIALING CENTER**

**Nurse Practitioners**

Adult  
Family  
Acute Care  
Family Psychiatric & Mental Health  
Gerontological  
Pediatric  
Adult Psychiatric & Mental Health  
Diabetes Management, Advanced

**Clinical Nurse Specialists**

Adult Health  
Diabetes Management, Advanced  
Adult Psychiatric and Mental Health Nursing  
Child & Adolescent Psychiatric and Mental Health Nursing  
Public/Community Health Nursing  
Gerontological Nursing  
Pediatric Nursing

**ONCOLOGY NURSING CERTIFICATION CORPORATION  
NATIONAL CERTIFICATION CORPORATION**

Neonatal Nurse Practitioner  
Women's Health Care Nurse Practitioner

**PEDIATRIC NURSING CERTIFICATION BOARD  
AMERICAN ACADEMY OF NURSE PRACTITIONERS**

**GENERAL INFORMATION**

1. **NAME AND/OR ADDRESS CHANGES:** If your name and/or address changes before the exam date, notify the Board of Nursing in writing. Include your former name, address, social security number, and whether or not you are a candidate for the nursing examination with the new name and/or address. Telephone calls are NOT accepted for these changes. Name and address changes can be faxed to (517) 373-2179.
2. **REFUND POLICY:** If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Nursing in writing to request a refund.
3. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 222.16174 (3). Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.
4. **CONTINUING EDUCATION:** This license has a continuing education requirement for renewal. Please check our website at [www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense) for more information on the specific requirements.

**PLEASE NOTE:** You are not required to complete any continuing education credits in order to renew your license for the first time because you will not have held your license for a full two-year period.

THE NURSE SPECIALTY CERTIFICATION WILL EXPIRE ON THE SAME DAY AS YOUR RN LICENSE. YOUR NURSE SPECIALTY CERTIFICATION CANNOT BE RENEWED UNTIL YOUR RN LICENSE IS RENEWED. HOWEVER, YOU CAN SUBMIT BOTH FOR RENEWAL AT THE SAME TIME.

**Board of Nursing**

P.O. Box 30193  
Lansing, MI 48909  
(517) 335-0918  
www.michigan.gov/healthlicense

## APPLICATION FOR NURSE SPECIALTY CERTIFICATION

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, certification will not be issued.

**Type or Print Only**

**I AM APPLYING FOR THE FOLLOWING :** Note: A separate application and fee must be filed for each certification desired.

- Nurse Practitioner
- Nurse Midwife
- Nurse Anesthetist

**If your R.N. License Expires:**

in 13-24 Months the Fee is \$52.00 71-4704-021156  
in 5-12 Months the Fee is \$38.00 71-4704-011156  
in 0-4 Months the Fee is \$52.00 71-4704-021156

\*If your current RN license expires within 120 days, you must pay the larger fee and your certification will be issued with your renewed, 2 year license.

Your check or money order drawn on a U.S. Financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

**Board Use Only**

License Number

Date of Licensure

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan RN Permanent I.D. Number and Expiration Date
Street Address		E-Mail Address
City	State	ZIP Code
Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)	

**SPECIALTY EDUCATION INFORMATION**

Name of Specialty Education Program Attended
Location (City and State)
Date of Attendance

**NURSE PRACTITIONER APPLICANTS ONLY:**

Name of school granting your Bachelor of Science degree in Nursing:

<b>CERTIFICATION</b>	
I certify that the above statements about my qualifications for a Michigan nurse specialty certification are true.	
Signature of Applicant:	Date:

Michigan Department of Community Health

**Board of Nursing**

P.O. Box 30193

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

**NURSE PRACTITIONER SPECIALTY CERTIFICATION**

Authority: Public Act 368 of 1978, as amended.  
If this form is not completed, certification will not be issued.

**SECTION I - APPLICANT INFORMATION**

**INSTRUCTIONS:** Applicant should complete Section I. Type or print your name exactly as it appears on your Registered Nurse application. Send this form to the appropriate certifying agency for completion of Section II. **This certification must be submitted directly to the Michigan Board of Nursing by the appropriate certifying agency.**

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan RN Permanent ID Number and Expiration Date:
Street Address		
City	State	ZIP Code
Signature		Date

**Indicate Agency of National Certification**

**AMERICAN NURSES CREDENTIALING CENTER**

Nurse Practitioners

- Adult
- Family
- Acute Care
- Family Psychiatric and Mental Health
- Adult Psychiatric and Mental Health
- Gerontological
- Diabetes Management, Advanced
- Pediatric Nurse Practitioner

Clinical Nurse Specialists

- Adult Health
- Diabetes Management, Advanced
- Adult Psychiatric & Mental Health Nursing
- Child & Adolescent Psychiatric & Mental Health Nursing
- Public/Community Health Nursing
- Gerontological Nursing
- Pediatric Nursing

**ONCOLOGY NURSING CERTIFICATION CORPORATION**

**NATIONAL CERTIFICATION CORPORATION**

- Neonatal Nurse Practitioner
- Women's Health Care Nurse Practitioner

**PEDIATRIC NURSING CERTIFICATION BOARD**

**AMERICAN ACADEMY OF NURSE PRACTITIONERS**

**SECTION II - CERTIFICATION OF LICENSURE**

**CERTIFYING AGENCY INSTRUCTIONS:** Please complete the following information. Return this certification directly to the Michigan Board of Nursing at the address above.

This is to certify that the person identified above has met the requirements for certification or recertification by the :

\_\_\_\_\_ Name of Certifying Agency

as a \_\_\_\_\_

\_\_\_\_\_ Date of Certification      \_\_\_\_\_ Certification Number      \_\_\_\_\_ Expiration Date

\_\_\_\_\_ Authorized Signature of Certifying Agency      \_\_\_\_\_ Date

\_\_\_\_\_ Print or Type name

(SEAL)

## Michigan Department of Community Health

## Board of Nursing

P.O. Box 30193

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

## CERTIFICATION OF NURSE PRACTITIONER EDUCATION

Authority: Public Act 368 of 1978, as amended.  
If this form is not completed, certification will not be issued.

**INSTRUCTIONS:** Applicant complete Section I. Type or print your name exactly as it appears on your Registered Nurse license. Send this form to the educational institution where you obtained your nurse practitioner training for completion of Section II. **This certification must be submitted directly to the Michigan Board of Nursing by the educational institution along with official transcripts of your nurse practitioner education.**

## SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	Michigan RN Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Signature of Applicant		Date

## SECTION II - CERTIFICATION OF NURSE PRACTITIONER PROGRAM

<p><b>CERTIFYING AGENCY INSTRUCTIONS:</b> Please complete the following information. Return this certification, along with a copy of the applicant's transcript or record of grades, directly to the Michigan Board of Nursing at the address above.</p>	
<p>Name of Educational Institution</p> <p>_____</p>	
<p>I certify that _____</p> <p style="text-align: center;">(Name of Applicant)</p>	
<p>completed a formal advanced nursing program at the above named educational institution that consisted of a combination of didactic and clinical training with a minimum of 120 hours or 30% of the program's hours devoted to classroom theory and a minimum of 360 or 30% of the program's hours devoted to supervised clinical practice in the specialty area. The program was a minimum of one academic year or nine months.</p>	
Signature of Program Administrator	Date
Print or Type Name	(SEAL)

Michigan Department of Community Health  
**Board of Nursing**  
 P.O. Box 30193  
 Lansing, MI 48909  
 (517) 335-0918  
 www.michigan.gov/healthlicense

**NURSE MIDWIFE SPECIALTY CERTIFICATION**

Authority: Public Act 368 of 1978, as amended.  
 If this form is not completed, certification will not be issued.

**INSTRUCTIONS:** Applicant complete Section I. Type or print your name exactly as it appears on your Registered Nurse license. Send this form to the designated certifying agency for completion of Section II. **This certification must be submitted directly to the Michigan Board of Nursing by the designated certifying agency.**

**SECTION I - APPLICANT INFORMATION**

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan RN Permanent ID Number and Expiration Date:
Street Address		
City	State	ZIP Code
Signature of Applicant		Date

**SECTION II - CERTIFICATION OF LICENSURE**

**CERTIFYING AGENCY INSTRUCTIONS:** Please complete the following information. Return this certification directly to the Michigan Board of Nursing at the address above.

This is to certify that:

the person identified above has met the requirements for certification or recertification by the American Midwifery Certification Board (AMCB)

**OR**

the person identified above has met the Continuing Competency Assessment requirements of the AMCB.

**American Midwifery Certification Board**

Date completed Continuing Competency Assessment Requirements \_\_\_\_\_

Date of Certification: \_\_\_\_\_

Certification Number: \_\_\_\_\_

Expiration Date : \_\_\_\_\_

\_\_\_\_\_

Authorized Signature - Certification

\_\_\_\_\_

Date

\_\_\_\_\_

Print or Type name

(SEAL)

Michigan Department of Community Health  
**Board of Nursing**  
 P.O. Box 30193  
 Lansing, MI 48909  
 (517) 335-0918  
 www.michigan.gov/healthlicense

**NURSE ANESTHETIST SPECIALTY CERTIFICATION**

Authority: Public Act 368 of 1978, as amended.  
 If this form is not completed, certification will not be issued.

**INSTRUCTIONS:** Applicant complete Section I. Type or print your name exactly as it appears on your Registered Nurse license. Send this form to the designated certifying agency for completion of Section II. **This certification must be submitted directly to the Michigan Board of Nursing by the designated certifying agency.**

**SECTION I - APPLICANT INFORMATION**

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan R.N. Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)	
Signature of Applicant		Date

**SECTION II - CERTIFICATION OF LICENSURE**

**CERTIFYING AGENCY INSTRUCTIONS:** Please complete the following information. Return this certification directly to the Michigan Board of Nursing at the address above.

This is to certify that the person identified above has met the requirements for certification or recertification by the :

**American Association of Nurse Anesthetists Council on Certification or Council on Recertification of Nurse Anesthetists**

Date of Initial Certification: \_\_\_\_\_

Date of Recertification: \_\_\_\_\_

Recertification Number : \_\_\_\_\_

Expiration Date: \_\_\_\_\_

---

Authorized Signature of Certifying Agency \_\_\_\_\_ Date \_\_\_\_\_

---

Print or Type Name \_\_\_\_\_ **(SEAL)**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.