

APPLICATION FOR LICENSURE BY REINSTATEMENT OR REACTIVATION



LICENSE TYPE:

- | | |
|--|-----------------|
| <input checked="" type="checkbox"/> Reinstate expired RN/LPN | <u>\$230.00</u> |
| <input type="checkbox"/> Reinstate expired APRN License and authority | <u>\$348.00</u> |
| <input type="checkbox"/> Reinstate expired APRN authority (only), DC RN license must be active | <u>\$230.00</u> |
| <input type="checkbox"/> Reactivate (Inactive License) | <u>\$34.00</u> |

**D.C. Board of Nursing
P.O. Box 37802
Washington, D.C. 20013**

EXPIRATION: RN licenses expire June 30th of even-numbered years
LPN licenses expire June 30th of odd numbered years

Prefix (Ms., Mrs., Mr., etc.):

--	--	--	--

First Name:

[illegible]

MI:

Last Name:

[illegible]

Suffix (Jr., Sr., etc.)

Date of Birth:

Social Security Number:

Student Security Number

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION

APPLICATION FOR LICENSURE BY REINSTATEMENT OR REACTIVATION

UPDATE HOME ADDRESS OR LOCAL/MAILING ADDRESS: (All official correspondence will be mailed to this address.) You are statutorily required to notify the Board in writing within 30 days of an address change. Failure to do so may result in non-receipt of a license, renewal notice or other official notices and can result in a disciplinary action or a fine.

Street Number and Street Name:

Apartment/Suite Number:

City:

State/Province/Territory:

ZIP:

Phone Number:

Email Address:

UPDATE BUSINESS OR MAILING ADDRESS: (This address will be made available to the public)

Street Number and Street Name:

Apartment/Suite Number:

City:

State/Province/Territory/Jurisdiction:

ZIP:

Phone Number:

Email Address:

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION**

APPLICATION FOR LICENSURE BY REINSTATEMENT OR REACTIVATION

LICENSURE STATUS REINSTATEMENT

Reinstatement of license **expired less than a year**. You must:

- Provide proof of having met CE requirements. Contact Hours: APRNs: 24; RNs: 24; LPNs: 18, completed within two (2) years immediately preceding the date of this application.

Reinstatement of license **expired 1- 5 years or greater than 5 years with an active license in another jurisdiction**. You must:

- Provide licensure verification.
- Provide proof of having met CE requirements. Contact Hours: APRNs: 24; RNs: 24; LPNs: 18 completed within two (2) years immediately preceding the date of this application date.

Reinstatement of license **expired more than 5 years** for applicants who do not have an active license in another jurisdiction. You must:

- Submit evidence of having completed a nurse fresher course

APRNS please note: Following the reinstatement of your active licensure status you may renew your Controlled Substances Registration (CSR) at www.hrla.doh.dc.gov or (<http://doh.dc.gov/node/155142>)

REACTIVATION TO ACTIVE STATUS

A RN or LPN on inactive status may reactivate their licensure status by submitting:

- Evidence of having met the board's continuing education requirement (LPN -18, RN-24) completed two (2) years immediately preceding application date.
- APRNs only: Request verification from certifying body regarding current certification status

VERIFICATION OF LICENSE

Verification of licensure status must be received from your **original jurisdiction of licensure** and current jurisdiction of licensure, if your original jurisdiction of licensure is not active, via:

NURSYS Verification: www.nursys.com.

NON-NURSYS Verification: If your licensure Board does not verify licensure status via NURSYS (Alabama; California; Kansas; Louisiana-PN; Oklahoma; West Virginia-PN) contact them to request documentation verifying your licensure status be emailed to dc.bon@dc.gov

Verification of APRN certification (See list of recognized Certification Programs below)

Ask certifying body to email verification of your current APRN certification to Nicole.Scott@dc.gov, Melondy.Franklin@dc.gov, or dc.bon@dc.gov

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION

APPLICATION FOR LICENSURE BY REINSTATEMENT OR REACTIVATION

STATE and FBI CRIMINAL BACKGROUND CHECK (CBC) COMPLIANCE

ALL APPLICANTS ARE REQUIRED TO HAVE COMPLETED A STATE CBC AND FBI CBC WITHIN 4 YEARS PRIOR TO SUBMITTING THIS APPLICATION.

- **If you have completed a CBC for DC licensure or your licensing board appears on the list below**, and you **have had** a State CBC and FBI CBC **within the last 4 years**, please fill in the date(s) that you completed the State CBC and FBI CBC. You will not be required to complete another CBC.
- **If your licensing board does not appear on the list below**, or you **have not had** a State CBC and FBI CBC completed **within the last 4 years**, access MorphoTrust at www.LIenrollment.com or call 1-877-783-4787 to pay fee and schedule an appointment to have your CBC completed.

Board	Date State CBC Completed	Date FBI CBC Completed
AL		
AR		
AZ		
CA-VN		
DE		
FL		
GA		
IA		
ID		
IL		
IN		
KS		
KY		
LA-RN		
MD	1/2017	1/2017
MI		
MN		
MO		
MS		
MT		
NC		
ND		
NE		
NJ		
NH		
NM		
NV		
OH		
OK		
OR		
RI		
SC		
SD		
TN		
TX		
UT		
VA		
WA		
WV-PN		
WY		

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION

APPLICATION FOR LICENSURE BY REINSTATEMENT OR REACTIVATION
SCREENING QUESTIONS

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this “yes or no” question, as any false information provided requires the Department of Health to proceed immediately to revoke your License for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be issued a license if you have failed to file your District tax returns.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

___ YES*

☒ NO

*IF YOU ANSWERED “YES” to this question, please submit proof of the arrangements you have made to pay the outstanding debt. If you do not have an approved payment schedule to pay the amount you owe or if no appeal is pending, the law requires that your application be denied.

Information presented above is in compliance with the requirement to submit with your application for licensure under the Clean Hands Before Receiving a License or Permit Act of 1996, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.)

Applicants Must Answer All of the Following Questions. If you answer “Yes” to any of the following questions provide a detailed explanation on a separate sheet of paper. Submit copies of relevant court reports, personnel actions, and actions taken against your license or other relevant documents.

- A. Have you suffered from any disability or used any drug(s) to such an extent that it has impaired your ability to practice your profession? ___ YES ☒ NO
- B. Have you ever been convicted or arrested for a crime or misdemeanor (other than a minor traffic violation)? ___ YES ☒ NO
- C. Please answer with respect to DC or any other jurisdiction/state: ___ YES ☒ NO

- (1) Have you withdrawn an application to practice your profession or voluntarily surrendered a license after formal charges have been filed against you or while under investigation?
- (2) Has any authority or peer review board taken adverse action against your license or privileges or informed you of any pending charges not previously reported to this Board?
- (3) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law?
- (4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board?
- (5) Have you voluntarily surrendered your license?
- (6) Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility?

- D. Have you been party to a malpractice action or had a malpractice action brought against you? ___ YES ☒ NO
- E. Have you been terminated from or resigned from a clinical or professional training program due to unsafe practice? ___ YES ☒ NO

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION**

APPLICATION FOR LICENSURE BY REINSTATEMENT OR REACTIVATION

LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

Khalilah Jefferson

PRINT NAME

7/19/17

DATE

[Signature]

LICENSEE SIGNATURE

PLEASE NOTE: PRINT AND MAIL ORIGINAL APPLICATION TO THE BOARD OF NURSING AND RETAIN A COPY FOR YOUR FILES.

Your application along with any required supporting documents must be mailed in the same package to:

D.C. Board of Nursing
P.O. Box 37802
Washington, D.C. 20013

REPORT FRAUD, WASTE AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.

IMPORTANT CONTACT INFORMATION

District of Columbia Health Regulation and Licensing Administration

Mailing Address:	District of Columbia Board of Nursing P.O. Box 37802 Washington, D.C. 20013
Application Processing Center:	District of Columbia Department of Health 899 North Capitol Street, NE, 1st Floor Washington, DC 20002
Check Application Status:	https://app.hrla.doh.dc.gov/Weblookup/
Website:	hrla.doh.dc.gov
Board of Nursing Email:	dc.bon@dc.gov
Criminal Background Check Unit Email:	doh.cbcu@dc.gov

Nursys Nurse License Verification for Endorsement

Your verification for endorsement summary:

Congratulations! Your license verification for endorsement has been electronically sent to the boards of nursing that you selected below.

Name: KHALILAH Q JEFFERSON [NCSBN ID: 8217813] \$30.00
- RN

Existing license(s): DISTRICT OF COLUMBIA, FLORIDA, GEORGIA, MARYLAND,
VIRGIN ISLANDS

**License verifications for endorsement have been electronically sent
to:** DISTRICT OF COLUMBIA

Total: \$30.00

Billing information:

Name:

[REDACTED]

E-mail:

[REDACTED]

Credit card type:

[REDACTED]

**Credit card
number:**

[REDACTED]

Authorization code:

[REDACTED]

Transaction ID:

[REDACTED]

Payment date:

07/18/2017

nursys.com

CHE IMAGE DETAIL REPORT

Seq#	Check Acct#	Amount	RT#	BatchID	Batch#	Check#	AuxOnUs	Box	DDA
000150	432926192	\$605.00	122016066	00789674	000001	000312577		08121	30954665

Processing Date : 09/13/2017

NM

2017 SEP 18 14:29

Life Line Screening of America
6150 Oak Tree Blvd. Ste 200
Independence OH 44131
216-581-6556

City National Bank
San Francisco, CA

15-1500
1220

312577

DATE 07/19/2017

PAY Six Hundred Five Dollars and 00/100 Cents

\$ *****605.00

TO
THE
ORDER
OF

DISTRICT OF COLUMBIA TREASURER
HRLA2
PO Box 37802
Washington DC 20013
United States

VOID AFTER 180 DAYS

[Signature]

Security Features required.    

⑈000312577⑈ ⑆122016066⑆ 432926192⑈

COPPIN STATE UNIVERSITY

2500 West North Avenue
Baltimore, Maryland 21216

Official transcript - all

Name : Khalilah Jefferson
Student ID: 1162904

This officially sealed and signed transcript is printed on SCRIP-SAFE[®] paper. A raised seal is not required. When photocopied, the word COPY and the name of the institution should appear. A BLACK ON WHITE OR A COLOR COPY SHOULD NOT BE ACCEPTED.

Karen Garland
Registrar of 2

Print Date : 2017-09-05
Send To : Khalilah Jefferson
[REDACTED]
Hyattsville, MD 20785-4711
United States

Degrees Awarded

Degree : Master of Science in Nursing
Confer Date : 2012-12-31
Plan : Master of Science in Nursing
Sub-Plan : Family Nurse Practitioner Specialization

Degree : Doctor of Nursing Practice
Confer Date : 2016-12-30
Plan : Doctor of Nursing Practice

External Degrees

Howard University
1999-05-18 Bachelor of Science

Beginning of Doctorate Record

Sum I 2015

Course	Description	Attempted	Earned Grade	Points
Program	Doctoral Program			
Plan	Doctor of Nursing Practice Major			
NURS 830	Research Methods & Design NP			12.000
NURS 831	Theoretical Perspectives in NP			9.000
TERM GPA :	TERM TOTALS :			21.000
CUM GPA :	CUM TOTALS :	6.00	6.00	21.000

SumII 2015

Course	Description	Attempted	Earned Grade	Points
Program	Doctoral Program			
Plan	Doctor of Nursing Practice Major			

Course	Description	Attempted	Earned Grade	Points
NURS 832	Foundations Evidenced Bas Prac			12.000
TERM GPA :	TERM TOTALS :			12.000
CUM GPA :	CUM TOTALS :			33.000

Fall 2015

Course	Description	Attempted	Earned Grade	Points
Program	Doctoral Program			
Plan	Doctor of Nursing Practice Major			
NURS 838	Capstone Project I			12.000
NURS 834	Analysis Health Care Del Sys			12.000
NURS 835	Epidemiology			9.000
TERM GPA :	TERM TOTALS :	9.00	9.00	33.000
CUM GPA :	CUM TOTALS :	18.00	18.00	66.000

Win 2016

Course	Description	Attempted	Earned Grade	Points
Program	Doctoral Program			
Plan	Doctor of Nursing Practice Major			
NURS 833	Global Health:Pers Health Care			12.000
TERM GPA :	TERM TOTALS :			12.000
CUM GPA :	CUM TOTALS :			78.000

Spr 2016

Course	Description	Attempted	Earned Grade	Points
Program	Doctoral Program			
Plan	Doctor of Nursing Practice Major			
NURS 836	Health Policy Analysis			12.000
NURS 837	Nurs Info Tech & Analysis			9.000
NURS 839	Capstone Project II			9.000
TERM GPA :	TERM TOTALS :			30.000
CUM GPA :	CUM TOTALS :	30.00	30.00	109.000

COPPIN STATE UNIVERSITY

2500 West North Avenue

Baltimore, Maryland 21216

Official transcript - all

Name : Khalilah Jefferson
Student ID: 1162904

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Karen Garland

Registrar

Page 2 of 2

NURS 641 PRIMARY HLTH CARE CHILD PRAC [REDACTED] 12.000
TERM GPA : [REDACTED] TERM TOTALS : 12.00 12.00 45.000
CUM GPA : [REDACTED] CUM TOTALS : 37.00 35.00 122.000

Spr 2012

Graduate Career Totals

CUM GPA : [REDACTED] CUM TOTALS : 56.00 54.00 189.000

Non-Course Milestones

Comprehensive Examination & Paper

Milestone Status: Not Completed

Graduate Research Paper

Milestone Status: Completed

An Examination of the Attitudes of Male and Female Graduate Students

Enrolled in a Rehabilitation Counseling Education Program Towards

Individuals with Disabilities

- Completed

----- End of Transcript -----

Course	Description	Attempted	Earned Grade	Points
Program	Graduate Nursing			
Plan	Family Nurse Practitioner Major			
NURS 505	HLTH SYS POL, ORG & FINANCE	[REDACTED]		6.000
NURS 512	RSRCH: URBAN FAMILY HLTH	[REDACTED]		12.000
NURS 520	EPIDEMIOLOGY	[REDACTED]		6.000
NURS 700	PRIM HLTH CARE FAMILY PRAC	[REDACTED]		16.000
TERM GPA :		11.00	11.00	40.000
CUM GPA :		48.00	46.00	162.000

Sum 1 2012

Course	Description	Attempted	Earned Grade	Points
Program	Graduate Nursing			
Plan	Family Nurse Practitioner Major			
NURS 500	ETHICS IN NURSING	[REDACTED]		6.000
Repeated	: Repeat - Include in GPA			
TERM GPA :		2.00	2.00	6.000
CUM GPA :		50.00	48.00	168.000

Fall 2012

Course	Description	Attempted	Earned Grade	Points
Program	Graduate Nursing			
Plan	Family Nurse Practitioner Major			
EDUC 501	STATS IN SOC&BEHAV SCIENCES	[REDACTED]		12.000
NURS 313	NON-THESIS RESEARCH	[REDACTED]		9.000
TERM GPA :		6.00	6.00	21.000
CUM GPA :		56.00	54.00	189.000

TO VERIFY: TRANSLUCENT GLOBE ICONS MUST BE VISIBLE WHEN HELD TOWARD A LIGHT SOURCE

THE WORDS "COPPIN STATE UNIVERSITY" AND "COPY" APPEAR WHEN PHOTOCOPIED

Verification Report
Printed for DISTRICT OF COLUMBIA
Acknowledged on

Personal Information

NCSBN ID	SSN	Name (Reporting Jurisdictions)	DOB (Reporting Jurisdictions)
8217813	***-**-6953	JEFFERSON, KHALILAH Q (MD) JEFFERSON, KHALILAH QUASHAY (GA,FL) JEFFERSON, KHALILAH Q. (DC) JEFFERSON, KHALILAH QUAYSHAY (VI)	01/18/1977 (ALL)

Licenses

Member Board Notifications	License	Date of Licensure	Expiration Date	License Status	Licensure Basis	Initial Licensure	Exam
	DC RN RN961391	06/29/2012	06/30/2014	NOT ACTIVE	ENDORSEMENT	08/29/2000	
	FL RN RN9202903	06/18/2003	04/30/2011	NOT ACTIVE	ENDORSEMENT	06/18/2003	
	GA RN RN190410	02/02/2009	01/31/2011	NOT ACTIVE	ENDORSEMENT	05/30/2007	
	MD RN R147535 Multistate	02/16/2017	01/28/2019	ACTIVE	EXAM	02/16/2000	02/02/2000
	VI RN 8074		12/31/2009	NOT ACTIVE	ENDORSEMENT	11/11/2001	

Address Information

Juris.	Address	City	State	Zip	Country
MD		SILVER SPRING	MD	20904	USA
GA		COVINGTON	GA	30016	USA
FL		COVINGTON	GA	30016	USA
DC		HYATTSVILLE	MD	20785	USA
VI		ST CROIX	VI	00823	USA

Education Information

Juris.	School Name	Graduation Date	Program	Degree	City	State
MD	HOWARD UNIVERSITY - BS	05/08/1999	RN	BACHELORS	WASHINGTON	DC
FL	HOWARD UNIVERSITY	05/08/1999	RN	BACHELORS	WASHINGTON D.C.	
DC	HOWARD UNIVERSITY	05/08/1999	RN	BACHELORS	WASHINGTON D.C.	
VI	HOWARD UNIVERSITY	05/08/1999	RN	BACHELORS	WASHINTON	DC

Discipline Information

There are no discipline records for this individual.

PLEASE NOTE:

* Records with a jurisdiction code of '?' have not yet been associated with a specific license.

The exam scores are not being provided or are not available. Please do not speed memo the individual board requesting exam scores.

REIN Pending (Paid \$605 MONK) RN 9601391
EXP 6/2014

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH - HEALTH REGULATION & LICENSING ADMINISTRATION

ADV

STERED NURSE LICENSURE APPLICATION



Health Regulation and
899 North Capitol Street
Washington, DC 20002
Email: dc.bon@dc.gov



of the District of Columbia
Department of Health



D.C. BOARD OF NURSING
ADVANCED PRACTICE REGISTERED NURSE APPLICATION

LICENSE TYPE

FEE (Non-Refundable)

- ☒ **APRN Licensure by Endorsement**
(Endorsing your RN licensing and APRN authority)
Select one (1) APRN Authority
- ☐ Nurse Anesthetist
 - ☒ Nurse Practitioner
 - ☐ Nurse Midwife
 - ☐ Clinical Nurse Specialist

\$375.00

☐ **RN Currently Licensed in DC License #** _____

\$230.00

If currently licensed as a RN in DC

Select one (1) added APRN Authority

- ☐ Nurse Anesthetist
- ☐ Nurse Practitioner
- ☐ Nurse Midwife
- ☐ Clinical Nurse Specialist

ADDING ADDITIONAL APRN AUTHORITY to APRN LICENSE

☐ **Select additional APRN Authority(ies)**

\$119.00

- ☐ Nurse Anesthetist
- ☐ Nurse Practitioner
- ☐ Nurse Midwife
- ☐ Clinical Nurse Specialist

PAYMENT: Make non-refundable check or money order payable to **DC Treasurer** and mail, along with this application, to:

D.C. Board of Nursing
P.O. Box 37802
Washington, D.C. 20013

Applicants must complete every section of this application and **submit the original application and all required supporting documents**. If more space is needed to fully answer questions, attach additional sheets with typed responses.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION

ADVANCED PRACTICE REGISTERED NURSE APPLICATION

GENDER: ☐ MALE ☒ FEMALE

HOME ADDRESS OR LOCAL/MAILING ADDRESS: (All official correspondence will be mailed to this address.) You are statutorily required to notify the Board in writing within 30 days of an address change. Failure to do so may result in non-receipt of a license, renewal notice or other official notices and can result in a disciplinary action or a fine.

Street Number and Street Name:

Apartment/Suite Number:

City:

							H	y	a	t	t	s	v	i	l	e			
--	--	--	--	--	--	--	---	---	---	---	---	---	---	---	---	---	--	--	--

State/Province/Territory:

ZIP:

M	D																		
---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Email Address:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

BUSINESS OR MAILING ADDRESS: (This address will be made available to the public)

Street Number and Street Name:

7	5	2	5	G	r	e	e	n	w	a	y	C	e	n	t	e	r		
D	R	I	V	E															

Apartment/Suite Number:

City:

2	1	2					G	r	e	e	n	b	e	i	t				
---	---	---	--	--	--	--	---	---	---	---	---	---	---	---	---	--	--	--	--

State/Province/Territory/Jurisdiction:

ZIP:

M	D																		
---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

3	0	1	-	6	6	9	-	1	8	7	0								
---	---	---	---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--

Email Address:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION

ADVANCED PRACTICE REGISTERED NURSE APPLICATION

NURSING SCHOOLS ATTENDED

List all nursing schools that you have attended beginning with the most recent at the top.

School Name, City, State, Country	Date of Graduation mm/yyyy	Degree/Certificate
Coppin State University Baltimore, MD	12/2016	DNP
Coppin State University Baltimore, MD	12/2012	MSN
Howard Univ. Washington DC	5/1999	BSN

CERTIFICATION

Provide the following information for each current APRN authority you are requesting:

Credentialing Body: American Academy of Nurse Practitioners
Certification Title: NP-C Specialty Area: Family Nurse Practitioner
Certification Number: F1013455 Expiration Date: 10/22/2018

Credentialing Body: _____
Certification Title: _____ Specialty Area: _____
Certification Number: _____ Expiration Date: _____

SECTION 3E. PROFESSIONAL LICENSURE IN OTHER JURISDICTIONS

MANDATORY FIELD	JURISDICTION	ACTIVE/ NOT ACTIVE	LICENSE NUMBER
Original licensure <u>Family Nurse Practitioner</u>	<u>MD</u>	<u>Active</u>	<u>R147535</u>
Current license (if license in original jurisdiction is not active)			

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION

ADVANCED PRACTICE REGISTERED NURSE APPLICATION

STATE and FBI CRIMINAL BACKGROUND CHECK (CBC) COMPLIANCE

ALL APPLICANTS ARE REQUIRED TO HAVE COMPLETED A STATE CBC AND FBI CBC WITHIN 4 YEARS OF SUBMITTING THIS APPLICATION.

- If your licensing board appears on the list below, and you have had a State CBC and FBI CBC within the last 4 years, please fill in the date(s) that you completed the State CBC and FBI CBC.
- If your licensing board does not appear on the list below, or you have not had a State CBC and FBI CBC completed within the last 4 years, access MorphoTrust at www.LIenrollment.com or call 1-877-783-4187 to pay for and schedule an appointment to have your CBC completed.

Board	Date State CBC Completed	Date FBI CBC Completed
AL		
AR		
AZ		
CA-VN		
DE		
FL		
GA		
IA		
ID		
IL		
IN		
KS		
KY		
LA-RN		
MD	1/2017	1/2017
MI		
MN		
MO		
MS		
MT		
NC		
ND		
NE		
NJ		
NH		
NM		
NV		
OH		
OK		
OR		
RI		
SC		
SD		
TN		
TX		
UT		
VA		
WA		
WV-PN		
WY		

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION

ADVANCED PRACTICE REGISTERED NURSE APPLICATION
SCREENING QUESTIONS

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Please read the information below carefully before responding to this "yes or no" question, as any false information provided requires the Department of Health to proceed immediately to revoke your License for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be issued a license if you have failed to file your District tax returns.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

___ YES*

☒ NO

*IF YOU ANSWERED "YES" to this question, please submit proof of the arrangements you have made to pay the outstanding debt. If you do not have an approved payment schedule to pay the amount you owe or if no appeal is pending, the law requires that your application be denied.

Information presented above is in compliance with the requirement to submit with your application for licensure under the Clean Hands Before Receiving a License or Permit Act of 1996, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.)

Applicants Must Answer All of the Following Questions. If you answer "Yes" to any of the following questions, provide a detailed explanation on a separate sheet of paper. Submit copies of relevant court reports, personnel actions, actions taken against your license or other relevant documents.

- A. Have you suffered from any disability or used any drug(s) to such an extent that it has impaired your ability to practice your profession? ___ YES ☒ NO
- B. Have you ever been convicted or arrested for a crime or misdemeanor (other than a minor traffic violation)? ___ YES ☒ NO
- C. Please answer with respect to DC or any other jurisdiction/state:
- (1) Have you withdrawn an application to practice your profession or voluntarily surrendered a license after formal charges have been filed against you or while under investigation? ___ YES ☒ NO
- (2) Has any authority or peer review board taken adverse action against your license or privileges or informed you of any pending charges not previously reported to this Board? ___ YES ☒ NO
- (3) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law? ___ YES ☒ NO
- (4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board? ___ YES ☒ NO
- (5) Have you voluntarily surrendered your license? ___ YES ☒ NO
- (6) Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility? ___ YES ☒ NO
- D. Have you been party to a malpractice action or had a malpractice action brought against you? ___ YES ☒ NO
- E. Have you been terminated from or resigned from a clinical or professional training program due to unsafe practice? ___ YES ☒ NO

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION & LICENSING ADMINISTRATION

ADVANCED PRACTICE REGISTERED NURSE APPLICATION

LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.



LICENSEE SIGNATURE

7/19/17

DATE

Khalilah Jefferson

PRINT NAME

REPORT FRAUD, WASTE AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.

IMPORTANT CONTACT INFORMATION

District of Columbia Health Regulation and Licensing Administration

Mailing Address:

D.C. Board of Nursing
P.O. Box 37802
Washington, D.C. 20013

DC Board of Nursing Location:

899 North Capitol Street, NE, 1st Floor, Washington, DC 20002

Check Application Status:

<https://app.hpla.doh.dc.gov/mylicense/>

Website:

hrla.doh.dc.gov

Board of Nursing Email:

dc.bon@dc.gov

Criminal Background Check Unit Email: doh.cbcu@dc.gov

CHE IMAGE DETAIL REPORT

Seq#	Check Acct#	Amount	RT#	BatchID	Batch#	Check#	AuxOnUs	Box	DDA
000150	432926192	\$605.00	122016066	00789674	000001	000312577		08121	30954665

Processing Date : 09/13/2017

MM

2017 SEP 13 PM 4:29

Life Line Screening of America
6150 Oak Tree Blvd. Ste 200
Independence OH 44131
216-581-6556

City National Bank
San Francisco, CA

15-1605
1220
312577

DATE 07/19/2017

\$ *****605.00

PAY Six Hundred Five Dollars and 00/100 Cents

TO
THE
ORDER
OF

DISTRICT OF COLUMBIA TREASURER
HRLA2
PO Box 37802
Washington DC 20013
United States

VOID AFTER 180 DAYS

[Signature]

Security Features Included
Divide on back.

⑈000312577⑈ ⑆122016066⑆ 432926192⑈



September 7, 2017

DC Board of Nursing, Dept. of Health
899 North Capitol Street, NE
First Floor
Washington, DC 20002

RE: Khalilah Quashay Jefferson, NP-C
Last 4 # of SSN- [REDACTED]

This is to verify that the American Academy of Nurse Practitioners Certification Board (AANPCB) has certified **Khalilah Quashay Jefferson** as a **Family Nurse Practitioner**. The certification number is **F1013455**, which is effective from **October 23, 2013** until **October 22, 2018**.

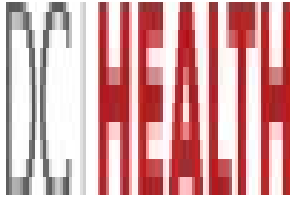
Please contact the Verification Department at (512) 637-0500 Ext. 543 or Certification@aanpcert.org if additional information is needed.

Sincerely,

Richard F. Meadows, MS, NP-C, FAANP
Chief Executive Officer

AMERICAN ACADEMY OF NURSE PRACTITIONERS CERTIFICATION BOARD

P.O. Box 12926, Austin, TX 78711-2926
Main (512) 637-0500 Toll-free (855) 822-6727 Fax (512) 637-0540
Email Certification@aanpcert.org www.aanpcert.org



HEALTH REGULATION AND LICENSING
ADMINISTRATION
BOARD OF NURSING
REGISTERED NURSE/ADVANCED PRACTICE
REGISTERED NURSE
RENEWAL APPLICATION INSTRUCTIONS



Licensure expiration date has been **extended to July 31, 2018**

Welcome RNs/APRNs to HRLA's new licensure portal! Instructions for completing the online application are below. You will be required to re-enter your demographic information.

PLEASE NOTE:

- Your previous **USERNAME AND PASSWORD WILL NOT WORK**. Click on **SIGN-UP** to establish a new **USERNAME AND PASSWORD**.
- You will **not** be able to verify the status of your renewed license via HRLA's "Licensee Look-up". **TO LOOK UP YOUR LICENSE NUMBER AND TO VERIFY LICENSURE STATUS, PLEASE ACCESS NURSYS.COM WEBSITE.**

BEFORE YOU START THE RENEWAL PROCESS, HAVE ELECTRONIC COPIES OF THE FOLLOWING DOCUMENTS HANDY SO THAT YOU CAN UPLOAD THEM DURING THE ONLINE APPLICATION PROCESS:

- Passport-type picture (required)
- Documents indicating Continuing Education (CE) Compliance (required)
- Document supporting name change (if relevant)
- Document(s) needed to support "Yes" response to Screening Questions (e.g. Conviction, termination, discipline by a board, etc.)
- Also have your license number, Social Security number and Visa or Mastercard available

Remember: Your previous USERNAME AND PASSWORD WILL NOT WORK. Click on SIGN-UP to establish a new USERNAME AND PASSWORD

APRNs NOTE: You must renew all of the following at the same time, online only:

- APRN license
- Controlled Substance Registration (CSR)
- Yellow Fever permit

You will not be able to renew these separately.

Questions? Send an email to: dcbon.renewal@dc.gov [Please read these instructions before contacting us. Thanks!]

LICENSURE RENEWAL FEES (Non-Refundable VISA or Mastercard payments are acceptable online)

RN Renewal	\$145.00
RN Renewal with APRN Renewal	\$263.00
(\$119.00 for each additional authority)	
If you don't plan to work in DC you may opt to place your license on "Inactive Status"	
APRN Control Substance Registration	\$130.00
RN Inactive Status	\$145.00
If you don't plan to work in DC you may opt to place your license on "Inactive Status".	

CONFIRMATION OF PAYMENT AND RENEWAL

Two emails will be sent, one acknowledging payment and one acknowledging licensure renewal, which will include a printable certificate. **Licenses will not be mailed.** Confirm your licensure status at Nursys.com. After August 30th, you will have to apply for Reinstatement of your license.

CRIMINAL BACKGROUND CHECK

Not required this renewal period.

PASSPORT-TYPE PHOTOS (Required)

Upload a recent passport type photo (head and shoulders, plain background)

APPLICANT NAME / DEMOGRAPHIC INFORMATION (Required)

Enter the name as it appears on the DC Nursing license. If there has been a name change, since the last renewal, upload a legal name change document (marriage certificate, divorce decree, court order)

RACE AND ETHNICITY DESIGNATION

Select from the dropdown menu choices.

ADDRESS: HOME (Required) and BUSINESS

Enter both, a home address and a business address, in the sections provided. PO Box is not acceptable.

UPDATE EMAIL ADDRESS (Required)

Enter a current email address.

SOCIAL SECURITY NUMBER (Required)

Enter a Social Security Number. This must be provided. A Tax ID number will NOT be accepted.

CURRENT DC LICENSE NUMBER (Required)

Enter the license number. Forgotten the license number? Go online at <https://app.hpla.doh.dc.gov/Weblookup/>

CONTINUING EDUCATION

(Not required if this is the first time ever renewing – **Required** for all others)

Upload Continuing Education (CE) documents or indicate CE Broker subscription status (cebroker.com). All Continuing Education must be relevant to your current field of practice.

CONTINUING EDUCATION AUDIT

Prior to the end of the renewal period, a separate notification will be sent to licensees randomly selected for audit.

RNs: UPLOAD ONE OF THE FOLLOWING DOCUMENT OPTIONS: (Required)

1. Contact Hours: CE certificate signed or stamped by the program sponsor. RNs must complete twenty-four (24) contact hours in current area of practice.
2. Academic: A transcript or evidence of completion of an undergraduate or graduate course in nursing or other course relevant to the practice of nursing.
3. Teaching: Evidence of development or instruction of a Continuing Education course or educational offering approved by the DC Board or a DC Board-approved entity. Applicants may receive four (4) contact hours for each approved course contact hour. (This is not an option for nurses who are employed as instructors or in-service educators).
4. Author or Editor: Evidence of authorship or editorship of a scholarly publication (book, chapter or peer reviewed periodical) that was published or accepted for publication during the licensure period.

APRNs: UPLOAD THE FOLLOWING DOCUMENTS (Required)

Twenty-four (24) contact hours in current area of practice. Fifteen (15) of the twenty-four (24) contact hours must include pharmacological content which must be listed on the CE certificate(s).

Free CE Courses Available Online from the DC Center for Rational Prescribing (DCRx)

DCRx, a service of the District of Columbia Department of Health, offers online continuing education (CE) courses free to DC healthcare professionals. Courses cover opioids, PrEP, taking a sexual history, diabetes, generic drugs, drug approval and promotion, medical cannabis, and other topics; new modules are available every year. Credit is available for nurses, physicians, physician assistants, and pharmacists. To access modules visit <http://doh.dc.gov/dcrx>.

SCREENING QUESTIONS (Required)

If there is a "Yes" response to questions (e.g. Recent arrest/conviction, termination, discipline by a board, etc.), upload the required documents and/or provide a complete explanation.

LICENSEE AFFIDAVIT (Required)

By acknowledging that the statements on the application are correct you are attesting, under penalty of perjury, that all information and attached documents are true to the best of your knowledge.



HEALTH REGULATION AND LICENSING
ADMINISTRATION
BOARD OF NURSING
REGISTERED NURSE/ADVANCED PRACTICE
REGISTERED NURSE
RENEWAL APPLICATION INSTRUCTIONS



PLEASE NOTE: All items with an asterisk (*) are required fields. If you have any questions, contact us at: [Click Here](#)

SECTION 1: LICENSURE TYPE & STATUS

Application Date	<input type="text" value="07/16/2018"/>
RN/APRN Renewal Application*	<input checked="" type="checkbox"/>
Licensure Type*	<input type="text" value="APRN Nurse Practitioner"/>
Other Licensure Type	<input checked="" type="checkbox"/> Yellow Fever <input checked="" type="checkbox"/> Controlled Substance Registration
Yellow Fever License Number	<input type="text"/>
CS Certificate Number	<input type="text" value="Starts with CN"/>
Additional APRN Authority	<input type="checkbox"/> Nurse Anesthetist <input checked="" type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse Midwife <input type="checkbox"/> Clinical Nurse Specialist
Renewal Options*	<input type="text" value="APRN with Control Substance Registration"/>
Photo Upload (Note : Maximum file size is 5MB)	<input type="text" value="khalilah jefferson.jpg"/> <input type="button" value="Add File..."/>

SECTION 2: APPLICANT INFORMATION

Pursuant to D.C. Official Code Section 3-1205.5(b) (2001) (Health Occupations Revision Act), **applicants are required to provide a Social Security Number (SSN)** on applications for a professional license.

OWNER (Note: Please select your Name from the look up)*

(If you could not find your name in **OWNER** Field please select "**DCHealth**" from the lookup)

First Name*
Middle Name
Last Name*
License Number*
Gender*
SSN(No Dashes)*
DOB*
Email*
Phone*
Race & Ethnicity

SECTION 3: NAME CHANGED DUE TO

If you are changing your name, you must provide legal documentation for the name change. Acceptable documentation for individuals includes a copy of a marriage certificate, divorce decree, or court order.

Name change due to

SECTION 4: MAILING ADDRESS

Note: A P.O. box may NOT be used for an address. Please provide a street address.

Indicate your preferred mailing address as an alternative to Email. Email will be the preferred means for future licensing communications.

Preferred Mailing Address*

SECTION 5: HOME ADDRESS

This information WILL NOT be made available to the public.

Address Street 1*
Address Street 2
City*
State*
Zip/Postal Code*
Country*

SECTION 6: BUSINESS ADDRESS

This information WILL BE made available to the public.

Business Address Street 1*
Business Address Street 2
Business Address State*
Business Address City*
Business Address Zip code*
Business Phone*
Business Email*

Acknowledge Contact Update Requirement

Licenses are required to update changes to their home address within thirty (30) days of the change of address. Send updated address to bon.dc@dc.gov

CONTINUING EDUCATION REQUIREMENT

RNs must complete twenty-four (24) contact hours of continuing education in the applicant's current area of practice. **APRNs** must complete a minimum of fifteen (15) of the twenty-four (24) contact hours in an educational offering that includes pharmacological content.

APRN CONTROLLED SUBSTANCES REGISTRATION (CSR) - you can renew your Controlled Substances Registration (CSR) after you renew your APRN license. Please see attached "DC Controlled Substances Registration Application."

Only contact hours obtained in the two (2) years immediately preceding the application date will be accepted. DO NOT send documentation verifying your compliance with the CE requirement unless asked to do so by the Board. The documents mailed to the Board will not be returned.

1. Contact Hour Option - May be used if you have completed a continuing education offering(s).

Documentation Needed - An original verification form from the accredited continuing education organization.

2. Academic Option - May be used when you have completed a course leading towards a degree in nursing or any academic course relevant to the practice of nursing.

Documentation Needed - Attach a copy of your transcript; or End of the semester report.

3. Teaching Option - May be used if you have developed and taught a course or educational offering approved by board approved accrediting body. You will be awarded four (4) Contact Hours for each approved contact hour.

[**Please note:** This is not an option for nurses required to develop and teach continuing education courses as a condition of employment].

Documentation Needed. - Verification form indicating your name, the name of the accrediting body and the number of contact hours; or Letter from an accrediting body acknowledging their approval of your course.

4. Author Or Editor Option - Author of a book chapter or peer reviewed article (if the manuscript has been published or accepted for publication during the period for which credit is claimed) or editor of a book during the renewal period. Twenty-four (24) Contact Hours Awarded.

Documentation Needed - Letter of acceptance; or Copy of title page of book or article (for articles, include name of journal, if not indicated on the title page); or Copy of page listing you as editor.

Are you enrolled in CE Broker*

Yes

Clean Hands

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100) to the District of Columbia Government as a result of any of the following:

- Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985)
- Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994)
- Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
- Past due taxes
- Past due District of Columbia Water and Sewer Authority service fees
- Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

Choose Yes if any of the above are true?*

☐

Yes

☒

No

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the Clean Hands Before Receiving a License or Permit Act of 1996, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

2. Since your last renewal, have you been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board? Provide court records*

☐

Yes

☒

No

3. Have you withdrawn an application for licensure/certification/registration to practice your profession in any jurisdiction? Has any authority or peer review board taken adverse action against your license or privileges? Have you been or are you currently being investigated by any authority or peer review board for any violation of state, federal, or local law? Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board?*
- ☐ Yes ☒ No
4. Do you have a physical or mental condition that currently impairs your ability to practice your profession? Provide written explanation*
- ☐ Yes ☒ No
5. Since your last renewal, have you been diagnosed or treated for substance abuse? Provide written explanation*
- ☐ Yes ☒ No
6. Since your last renewal, have you been involved in a malpractice suit? If yes, provide date of incident, allegation, and disposition of case*
- ☐ Yes ☒ No
7. Since your last renewal, have you been terminated or asked to resign from employment due to unsafe practice? Provide written explanation*
- ☐ Yes ☒ No
8. Do you currently practice your profession in the District of Columbia?*
- ☒ Yes ☐ No

Control Substance Questions

1. Has the applicant been convicted of a felony in connection with controlled substance (CS) under DC, State or Federal Law? *
- ☐ Yes ☒ No
2. Has the applicant ever surrendered or had a controlled substance registration revoked, suspended or denied? *
- ☐ Yes ☒ No

Demographics (WFS - Workforce Survey)

Dear Nurse Colleagues,

On behalf of the District of Columbia Board of Nursing, I want to thank you for participating in this important workforce survey for Registered Nurses and Advanced Practice Registered Nurses. Please take a few minutes to complete the attached workforce survey which will allow the Board of Nursing and the Health Regulation and Licensing Administration to accurately capture, quantify, and analyze our current nursing workforce demographics. This survey will provide the information needed by the DC health care community to develop strategies for building the capacity needed to meet the workforce needs of the future.

The data will be used for workforce statistical analyses and reporting purposes ONLY.

We appreciate your cooperation and support.

Thank you.
Amanda Liddle, RN, DrPH, FAAN
Chairperson
District of Columbia Board of Nursing

1. What is your gender?
2. Are you of Hispanic or Latino origin?
3. What is your race?
4. In what year were you born?

EDUCATION

1. Highest Level of Education
2. What type of nursing degree/credential qualified you for your first U.S. nursing license? *
3. What is the name of the school (education program) you graduated from that qualified you for your first U.S. RN license?
4. Date of Graduation*
5. In what city was this education program located? *
6. In what state was this education program located? *

7. What is your highest level of nursing education? **Doctoral degree-Nursing Practice (DNP)**
8. Highest level of education in another field **Not applicable**

License/Certification Information

1. Licensure Type **Advanced Practice RN license(APRN)**
2. Year of initial U.S. RN licensure **2000**
3. In what country were you initially licensed as an RN? **USA**
4. Year of initial U.S. APRN licensure **2013**
5. In what country were you initially licensed as an APRN? **USA**
6. License Status* **Active License**
7. Indicate whether you are credentialed in to practice as any of the following: (Select all that apply.)
- ☒ Certified Nurse Practitioner
 - ☐ Clinical Nurse Specialist
 - ☐ Certified Registered Nurse Anesthetist
 - ☐ Certified Nurse Midwife
 - ☐ Not credentialed as any of the above

Employment Information

1. What is your employment status?
- ☒ Actively employed in nursing or in a position that requires a nurse license full-time
- ☐ Actively employed in nursing or in a position that requires a nurse license part-time
- ☐ Actively employed in nursing or in a position that requires a nurse license on a per-diem basis
- ☐ Actively employed in a field other than nursing full-time
- ☐ Actively employed in a field other than nursing part-time
- ☐ Actively employed in a field other than nursing on a per-diem basis
- ☐ Working in nursing only as a volunteer
- ☐ Unemployed, seeking work as a nurse
- ☐ Unemployed, not seeking work as a nurse
- ☐ Retired
2. Reason for being unemployed WFS (If unemployed, please indicate the reasons) **--select an item--**
3. In how many positions are you currently employed as a nurse? **1**
4. How many hours do you work during a typical week in all your nursing positions? **40**
5. Please indicate the state and zip code of your primary employer **DC**
6. Please identify the type of setting that most closely corresponds to your nursing practice position. **Public Health**
7. Please identify the position title that most closely corresponds to your nursing practice position. **Advanced Practice Registered Nurse**
8. Please identify the employment specialty that most closely corresponds to your RN nursing practice position. **Women's Health**

SECTION 7 : RENEWAL OPTIONS

Renewal Period : April 1st - June 30th
Late Renewal Period : July 1st - Aug 30th

Renewal Fee Options

APRN with Control Substance Registration - \$393

Payment

[Please click here to make a payment](#)

Please Check your Email for Confirmation of Your Transaction Receipt, Copy and Paste your Transaction ID in following box.

Transaction ID*

[REDACTED]

Applicant Signature

☒ I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

Initials*

KJ

Today's Date*

07/16/2018



October 23, 2018

DC Board of Nursing, Dept. of Health
899 North Capitol Street, NE
First Floor
Washington, DC 20002

RE: Khalilah Quashay Jefferson, NP-C
Last 4 # of SSN- [REDACTED]

This is to verify that the American Academy of Nurse Practitioners Certification Board (AANPCB) has certified **Khalilah Quashay Jefferson** as a **Family Nurse Practitioner**. The certification number is **F1013455**, which is effective from the original date **October 23, 2013** until **October 22, 2023**.

Please contact the Verification Department at (512) 637-0500 Ext. 543 or Certification@aanpcert.org if additional information is needed.

Sincerely,

Richard F. Meadows, MS, NP-C, FAANP
Chief Executive Officer

AMERICAN ACADEMY OF NURSE PRACTITIONERS CERTIFICATION BOARD

P.O. Box 12926, Austin, TX 78711-2926
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