OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
7 Eagle Square - Concord, N.H. 03301-4980
Telephone 603-271-2152

UNIVERSAL APPLICATION FOR LICENSE RENEWAL

Profession for which application is being filed:_____

License Number:_____ Expiration Date (MM/DD/YYYY):_____

APPLICANT INFORMATION BASED ON TYPE OF PERSON

For individuals:

Full Legal Name:_____
Suffix, such as "Jr." or "III", if any

Other name(s) in which applicant holds or has held a professional license:_____

_____

Date of birth (MM/DD/YYYY):_____ Last 4 digits of SSN*:_____
*For confirmation of identity

Designated email address*:_____
* Email address to which notices, license will be sent

Home Physical Address:_____
Street name & number, Apt. # if any Municipality County State Zip Code Country if not US

Home Mailing Address: ☐ Check if same as physical address

IF DIFFERENT:_____
Street name & number or PO Box number Town/City State Zip Code Country if not US

Home/Personal Telephone Number:_(____)_____-_____

Office/Place of business name:_____

Address:_____
Street name & number Municipality State Zip Code Country if not US

Telephone number: _(____)_____-_____

Other locations where licensee routinely practices name:_____

Address:_____
Street name & number Municipality State Zip Code Country if not US

Telephone number: _(____)_____-_____

Applicant is: ☐ employee ☐ subtenant ☐ independent contractor ☐ owner

Applicant is (check if applicable): ☐ Applying for facilitated licensure
☐ Currently on active military duty*
☐ Legally married to an individual who is currently on active military duty*
* "On active military duty" means on active duty in the U.S. armed forces.

Information needed for workforce analysis, all individuals (ref. Plc 308.06(b)(9)):

a. Highest level of education, whether or not related to the profession in which licensure is being sought [drop-down list, select one: ☐ High school diploma or equivalency; ☐ Some college, no degree; ☐ Technical/Vocational Certificate; ☐ Associate's Degree; ☐ Bachelor's Degree; ☐ Master's Degree; ☐ Post-graduate training; ☐ Professional/Doctorate Degree; ☐ Postdoctoral training; ☐ Prefer not to answer]

b. Relative to the applicant's employment status, whether the applicant is: [drop-down list, select one: ☐ Actively working in a position that requires this license ☐ Actively working in a position in the same profession that does not require this license ☐ Actively working in a different profession ☐ Not currently working ☐ Retired ☐ Prefer not to answer]

c. Relative to the applicant's employment plans for the next 2 years, whether the applicant intends to: [drop-down list, select one: ☐ Increase hours in a field related to this license ☐ Decrease hours in a field related to this license ☐ Seek employment in a field unrelated to this license..☐ Retire ☐ Continue as is ☐ Not sure or plans unknown ☐ Prefer not to answer

d. Identification of the specialty, field, or area of practice in which the applicant spends the most professional time [drop-down list based on profession, including ☐ Prefer not to answer]

e. Does the applicant use telehealth to deliver services to patients? [drop-down list, select one: ☐ Yes ☐ No ☐ Prefer not to answer]

f. The state in which the applicant's primary practice is located, if applicable [drop-down list of U.S. states and territories plus ☐ Not applicable and ☐ Prefer not to answer]

g. The 5-digit zip code of the applicant's primary practice location, if applicable:___ [open text field] ☐ Prefer not to answer

h. Relative to the applicant's current employment arrangement at their principal practice location, whether the applicant is [drop-down list, select all that apply: ☐ Self-employed or a consultant ☐ Salaried employee ☐ Hourly employee ☐ In temporary employment or Locum Tenens ☐ Other arrangement ☐ Not employed ☐ Prefer not to answer]

i. In the applicant's primary employment or practice, whether the applicant's primary role is that of: [drop-down list, select all that apply: ☐ Administrator ☐ Clinical practitioner ☐ Faculty or other educator ☐ Researcher ☐ Other ☐ Not applicable ☐ Prefer not to answer]

Information needed for workforce analysis, applicants in any health care field (ref. Plc 308.06(b)(10):

a. Identification of the practice setting at the applicant's primary practice location [drop-down list based on profession plus ☐ Prefer not to answer]

b. What population groups does or will the applicant provide(s) services to? [drop-down list, select all that apply: ☐ Newborns to 2 years ☐ Children ages 2-10 ☐ Adolescents ages 11-19 ☐ Adults ☐ Geriatrics ages 65+ ☐ Pregnant women ☐ Veterans ☐ Incarcerated individuals ☐ Individuals with disabilities ☐ Individuals who speak a language other than English ☐ Medicaid ☐ Medicare ☐ Sliding Fee Scale ☐ None of the above ☐ Prefer not to answer]

c. An estimate of the number of hours per week the applicant spends or expects to spend at their primary practice location [drop-down list, select one: ☐ 0 hours per week/Not applicable ☐ 1-4 hours per week ☐ 5-8 hours per week ☐ 9-12 hours per week ☐ 13-16 hours per week ☐ 17-20 hours per week ☐ 21-24 hours per week ☐ 25-28 hours per week ☐ 29-32 hours per week ☐ 33-36 hours per week ☐ 37-40 hours per week ☐ 41 or more hours per week ☐ Prefer not to answer]

d. An estimate of the number of hours per week the applicant spends or expects to spend in direct patient care [drop-down list, select one: ☐ 0 hours per week/Not applicable ☐ 1-4 hours per week ☐ 5-8 hours per week ☐ 9-12 hours per week ☐ 13-16 hours per week ☐ 17-20 hours per week ☐ 21-24 hours per week ☐ 25-28 hours per week ☐ 29-32 hours per week ☐ 33-36 hours per week ☐ 37-40 hours per week ☐ 41 or more hours per week ☐ Prefer not to answer]

For applicants in any health care field, does applicant intend to practice in New Hampshire more than 50% of the time, whether in-person or by telehealth? ☐ Yes ☐ No

For entities:

Full Legal Name*:_____

*Name shown on document(s) that created the entity

Each other name used when doing business in New Hampshire:_____

_____

Legal form (check one): ☐ Corporation ☐ LLC ☐ Professional Association ☐ Partnership

☐ Other:_____

Jurisdiction in which formed:_____ Date of Formation (MM/DD/YYYY):_____

Employer ID number or other federal tax ID number assigned by the IRS:_____

Primary physical address in NH:_____

Street name & number, Suite # if any Municipality County Zip Code

NH mailing address:: ☐ Check if same as physical address

IF DIFFERENT:_____

Street name & number or PO Box number Town/City Zip Code

Office of Professional Licensing and Certification
7 Eagle Square - Concord, New Hampshire 03301
(603) 271-1452

Main telephone number: ( ) -

Designated email address*:

* Email address to which notices, license will be sent

Name of Authorized Signer (AS):

AS Telephone Number: ( ) - AS email:

Other contact individuals (authorized to interact with OPLC regarding the application, issued license) (if any):

Name	Telephone Number	Email Address

ALL APPLICANTS:

Information on Current Licensure* in Other Jurisdictions:

Jurisdiction	License Number	Date most recently licensed	Status (in good standing, expired, suspended, revoked, denied renewal)

* Includes licenses, certificates, registrations, or other form of approval required to practice

Background/Character Questions ("you" means the applicant; "not previously reported" does not include anything not required to be reported for initial licensure):

Questions:	Yes	No
During the last 27 months or not previously reported, have you been found guilty of or entered a plea of no contest to any felony or misdemeanor?		
During the last 27 months or not previously reported, have you been the subject of any disciplinary action by any professional licensing authority?		
During the last 27 months or not previously reported, have you been denied a license or other authorization to practice in any jurisdiction?		
During the last 27 months or not previously reported, have you surrendered a license or other authorization to practice issued by any jurisdiction in order to avoid or settle disciplinary charges?		
Are you now or do you have any reason to believe that you will soon be the subject of a disciplinary proceeding, settlement agreement, or consent decree undertaken or issued by a professional licensing board of any jurisdiction?		
During the last 27 months or not previously reported, has any malpractice claim been made against you?		
During the past 27 months or not previously reported, have you, for disciplinary reasons, been put on administrative leave, been fired for cause other than staff reductions from a position at your place of employment, or had any privileges limited, suspended, or revoked in any professional setting?		
During the past 27 months or not previously reported, have you committed any act(s) that would violate the laws and/or rules that govern the profession in which you are licensed?		

Does applicant have a DEA number*? ☐ No ☐ Yes (provide number):

Does applicant store, administer, or dispense controlled drugs in a setting that is not regulated under RSA 318 relative to pharmacies and pharmacists? ☐ No ☐ Yes (identify location):

Disclosure of Contact Information*:

For individuals: Do you consent to the disclosure of any of your personal contact information? Check applicable column for each item:

Information	Yes, I consent to disclosure	No, do not disclose
Home or other personal telephone number		
Designated email address		
Home address		

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Information	Yes, I consent to disclosure	No, do not disclose
Home mailing address (if different from home address)		

For entities: Do you consent to the disclosure of your designated email address? ☐ No ☐ Yes

** OPLC will not disclose this information unless authorized by you, unless ordered to do so by a court of competent jurisdiction.*

For applicants in any health care profession (information required by RSA 125:25-c):

Do you have an ownership interest in any diagnostic or therapeutic service(s) or company(ies)? ☐ No ☐ Yes

If yes, provide the following for each service or company:

Name	Address	Specific Diagnostic/Therapeutic Services Offered

Required Documentation

Each applicant must provide the following with this application:

- A clear explanation, including all relevant facts, the date(s) of the action, and the sanction(s) imposed, of any "yes" answer provided to a background and character question; and
- If a credential from a regional or national organization is required for renewal licensure, proof that the applicant holds the credential.

Each applicant on active military duty must provide proof of service status in the form of verification from the Defense Finance and Accounting Service at https://www.dfas.mil/garnishment/verifyservice/.

Each applicant for facilitated licensure as a military spouse must provide:

(1) Proof of the spouse's service status as stated above, and

(2) Proof of marriage in the form of either:

a. A copy of the front and back of the applicant's current military spouse identification card; or

b. A copy of the applicant's official marriage certificate, and, if the certificate is not in English, an English translation of the certificate that is certified by the translator as being an accurate translation;

Each applicant that is an entity must provide:

(1) A copy of the legal document that confers authority on the authorized signer to sign the application on the applicant's behalf; and

(2) Confirmation from the New Hampshire Secretary of State's Office that the entity applying for licensure is in good standing and authorized to do business in New Hampshire.

Continuing Education/Continuing Competence

- For professions that require proof that applicable continuing competence requirements have been met, the applicant shall provide the required proof with the application.
- For professions that do **not** require proof that applicable continuing competence requirements have been met, **submission of this application constitutes an attestation that the applicant has met the requirements**.

Fee

Application-Related Fee* - as stated in Plc 1002, except no fee is required for facilitated licensure

* For renewal licensure, the application processing and licensing fee specified in Plc 1002 for the license being applied for

If fee is paid by check or money order, the check or money order should be made payable to "Treasurer, State of New Hampshire." If your application is denied, the Application-Related Fee will not be refunded.

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Signature and Attestation

By signing below, the applicant attests that:

- The applicant is not under investigation by any professional licensing board and the applicant's credentials have not been suspended or revoked by any professional licensing board, or a written explanation of each such occurrence is being submitted;
- If required by applicable law, the applicant has completed the survey or opt-out form provided by the Office of Rural Health, Department of Health and Human Services;
- The information and documentation provided are true, complete, and not misleading to the best of the applicant's knowledge and belief;
- The applicant understands that providing false or misleading information constitutes grounds for denial, suspension, or revocation of a license; and
- The applicant understands that knowingly providing false material information constitutes a misdemeanor under RSA 641:3 relative to falsification in official matters.

Applicant's Signature:_____

Date Signed:_____