PMHS Request for Reinstatement

Name:_____

Last 4 Digits of SSN:_____

Previously Held Certification Number:_____

Date:_____

Your certification may be reinstated up to 18 months from the date of expiration and can be reinstated one time only.

After your certification is reinstated, you must submit your online recertification application before the consecutive recert period ends January 31st to avoid a late fee or, between February 1 and February 28 with a late fee.

Tip! It's best to reinstate your certification as soon as possible because you will be required to meet the recertification requirements for the reinstatement year **plus** recertify online for the current year. *If you reinstate and recertify between 2/1 and 2/28, you will owe late enrollment fees for two years.* Please see below:

- Reinstate & recert by 1/31 – Reinstatement Fee + Late Fee + Recert Fee
- Reinstate & recert 2/1 – 2/28 – (Reinstatement Fee + Late Fee + Recert Fee) + (Online recert fee + Late Fee)

All documents must be emailed as one PDF to recert@pncb.org or faxed as one document to 301-330-1504. Our office will contact you regarding your reinstatement request.

1. Provide a copy of your current APRN license
2. Provide a copy of your current certification documents showing an expiration date
3. Choose your recertification option, provide supporting documentation, along with entering this information on your ReCErt Tracker page
    a. Contact Hours – Copy of CE certificates for hours being documented. The documentation must include the date contact hours were earned/awarded, the number of contact earned and the name of the accrediting agency.
        i. PNCB Pediatric Updates – Only completed modules may be used. Name of of module(s):
        a._____
        b._____
    b. Professional Practice Learning (maximum of 3 PPL activities each equal 5 contact hours)
        i. Clinical Practice – Letter from your employer or clinical practice hour form
        i. Preceptor – Letter from sponsoring institution on official letterhead and signed by the appropriate authorizing person indicating responsibilities as a preceptor and dates of precepting.
        ii. Authorship - For journal articles, provide proof of authorship by submitting a copy of the title page with the title, your name as author, date of publication, publisher and edition and /or chapter title, your authorship and publication date. If the journal or text is not yet in print, the auditee may submit a letter of acceptance from the publisher.
        iii. Lectures - Provide a national or regional conference program brochure that lists you as a presenter, the program title and date. Or, present content outline showing the program title, date and location of the program, the name of the sponsoring organization, the auditee's name as a presenter, and the length of the presentation. If education materials were created for public education or patient teaching, provide a copy of the lecture materials that lists you as the lecturer, the lecture title and date.
        iv. Scholarly Poster – Provide documentation demonstrating the poster content and acceptance of the poster by the sponsoring organization.
        v. Committee Membership – Provide documentation confirming Local, state, or national level as an officer or committee task force member for an organization related to pediatric BMH concerns.
    c. Academic Credit – Provide an unofficial transcript documenting completion of 1 semester or quarter hours of academic credit. (10contact hours).
4. Update your contact information, including your email address, by going to www.pncb.org and clicking the "My PNCB Portal". After logging-in, click "Your Account, Contact Information & Wallet Card" then "Your Profile & Contact Information" to update your information.
5. Update your licensure information by going to www.pncb.org and clicking "ReCErt Tracker".

Pediatric Nursing Certification Board, Inc.
Verification of Clinical Practice Hours

To be used only if you selected the clinical practice hours' as a PPL activity.

Name _____

Last 4 Digits of Social Security Number ____

To be signed by a supervisor who can verify your nursing clinical practice hours.

I attest that _____ practiced _____ hours
(Name of Nurse)

at _____ from _____ through _____
(Name of Clinical Setting)

Supervisor's Signature _____

Supervisor's Title _____

Supervisor's Contact Email or Phone Number _____

Date Signed _____

The above signature attests to the accuracy of the above practice statement.