

**PRACTICAL/VOCATIONAL NURSING  
EMERGENCY TEMPORARY PERMIT REGISTRATION FORM  
Louisiana State Board of Practical Nurse Examiners**

3421 North Causeway Blvd, Ste. 505, Metairie, Louisiana 70002 Telephone: 504-838-5791 Fax: 504-838-5279  
Email: [disaster@lsbpne.com](mailto:disaster@lsbpne.com)

NOTE: DURING A DISASTER, IF OFFICE PHONE LINES ARE DOWN OR UNMANNED, THE EMERGENCY CELLULAR PHONE WILL BE ACTIVATED AT 318-489-0636

Instructions: Complete this form and fax to 504-838-5279 or email to [disaster@lsbpne.com](mailto:disaster@lsbpne.com). You must include a copy of your driver's license or other government issued photo I.D. and a copy of a current, valid license to practice practical/vocational nursing in another state in the United States. Forms submitted by email must have the required attachments scanned and submitted with the emailed form.

1. Name: \_\_\_\_\_  
                    First                                      Middle                                      Maiden                                      Last

2. Mailing Address in Louisiana: \_\_\_\_\_

3. Permanent Mailing Address: \_\_\_\_\_

4. Cell Phone: (\_\_\_\_) \_\_\_\_\_ Local/LA Phone: (\_\_\_\_) \_\_\_\_\_

5. Email Address: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

6. Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

7. City, State, and County/Parish of Birth: \_\_\_\_\_

8. Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

9. Health Care Agency/Shelter (where you will provide nursing services):

Agency/Shelter Name and Address: \_\_\_\_\_

Agency/Shelter Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Name and Credentials of Immediate Supervisor: \_\_\_\_\_

10. I, the undersigned applicant for an emergency temporary permit as a licensed practical/vocational nurse, attest that: I hold a current license to practice practical/vocational nursing in the United States; I have a negative history for criminal activity, a negative history for chemical dependency, and a negative history for complaints against and/or related to any and all licenses held for any profession in any state or U.S. territory.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**GIVE THE PHYSICAL ADDRESS, EMAIL ADDRESS, OR FAX # YOU WOULD LIKE THE PERMIT SENT TO:**