



Arkansas State Board of Nursing

University Tower Building
1123 South University Avenue, Suite 800
Little Rock, Arkansas 72204

PHONE 501.686.2700
FAX 501.686.2714
www.arsbn.org

INSTRUCTIONS FOR COMPLETION OF CERTIFICATE OF PRESCRIPTIVE AUTHORITY INITIAL APPLICATION

TO: Advanced Practice Nurse

When you become licensed as an Advanced Practice Nurse, you may be eligible to apply for a Certificate of Prescriptive Authority. Please read the following information carefully.

REQUIREMENTS

1. You must be currently licensed in the state of Arkansas as an Advanced Practice Nurse.
2. You must submit notarized documentation of successful completion of pharmacology coursework, which shall include pharmacokinetics principles, their clinical application and the prescription of pharmacological agents in the prevention and treatment of illness and the restoration and maintenance of health. Coursework shall contain a minimum of:
 - a. Three graduate semester credit hours of a post-baccalaureate pharmacology course from an accredited college or university within two years immediately prior to date of application to Board; **or**
 - b. Forty-five (45) contact hours (a contact hour is fifty (50) minutes) of continuing education in a pharmacology course which includes a competency component, offered by an accredited college or university, within two (2) years immediately prior to the date of application to the Board; **or**
 - c. A three graduate semester credit hour pharmacology course included as part of an advanced practice nursing education program, within five years immediately prior to the date of application to the Board.
3. You must submit notarized documentation of a minimum of three hundred clock hours preceptorial experience in the prescription of drugs, medicines and therapeutic devices with a qualified preceptor, to be **initiated** with the pharmacology course and to be **completed within one year** of the beginning of the course. (Preceptor experience completed as a part of the formal educational program in which the pharmacology course is taught will meet the three hundred (300) clock hour requirement.)
4. Submission of an **original** current collaborative practice agreement with an Arkansas licensed physician who has a practice comparable in scope, specialty, or expertise to yours. The collaborative practice agreement should include, but not be limited to:
 - a. Availability of the collaborating physician(s) for consultation or referral;
 - b. Methods of management of the collaborative practice, which shall include the use of protocols for prescriptive authority;
 - c. Plans for coverage of the health care needs of clients (where clients are referred to) in the emergency absence of the advanced practice nurse:
 - d. Plan for coverage (who APN will consult with) in the emergency absence of the collaborating physician;
 - e. Provision for quality assurance;
 - f. Signatures of the advanced practice nurse and collaborating physician(s), stating their signatures signify mutual agreement to the terms of the collaborative practice. (If signatures are on a separate sheet from the agreement, include this statement on the sheet with signatures.)
 - g. Arkansas medical license number of collaborating physician;
 - h. Work site name(s) and address(es);
 - i. Collaborating physician's work site address (if different from your work site); and
 - j. Statement that APN will limit prescribing to area of educational preparation and certification.
5. You must submit a completed notarized application and appropriate fee of \$150.00 (application will be returned if all areas are not completed). **FEES ARE NON-REFUNDABLE.**

FEES ARE
NON-REFUNDABLE

FOR OFFICE USE
Certificate Number _____
Date Issued _____

ARKANSAS STATE BOARD OF NURSING
UNIVERSITY TOWER BUILDING
1123 SOUTH UNIVERSITY, SUITE 800
LITTLE ROCK, ARKANSAS 72204
501.686.2700

CERTIFICATE OF PRESCRIPTIVE AUTHORITY APPLICATION

Full Name _____
(MISS, MS, MRS, OR MR) FIRST MIDDLE MAIDEN LAST

Address _____
STREET CITY STATE ZIP

Mailing Address _____
STREET/P.O. BOX CITY STATE ZIP

Social Security Number _____ Telephone No. () _____

Birthdate _____ RN License # _____ APN License # _____
Month/Day/Year

Practice Setting Name _____ Phone _____

Practice Setting Address _____
Street City State ZipCode

Currently Certified As:
 ANP CRNA CNS CNM

Certifying Body _____ Exam Title _____

Advanced Practice Nursing Program _____

Have you ever been convicted of a misdemeanor or felony or pled guilty or nolo contendere to any charge in any state or jurisdiction? YES NO
(If yes, please include a copy of the court docket, plea agreement, or conviction papers, and evidence that fines, restitution are paid.) (PLEASE NOTE: WITH THE EXCEPTION OF DWI, TRAFFIC VIOLATIONS DO NOT CONSTITUTE A CRIME)

Have you ever had any license, certificate or registration disciplined (revoked, suspended, placed on probation, or reprimanded) or voluntarily surrendered in any state or jurisdiction? YES NO (If yes, include copy of Facts and Finding from Board and evidence of reinstatement of license)

Are you currently under investigation in any state or jurisdiction? YES NO

Do you currently engage in drug-related behavior, including the use of mood-altering drugs/substances and/or alcohol that would affect your functional abilities to perform while working as a nurse? YES NO

In the last two years, have you been the subject of a chemical or alcohol dependency intervention or participated in chemical or alcohol dependency treatment/rehabilitation? YES NO (If yes, submit all relevant documents, such as rehab program completion, support group meetings, drug screens, etc.)

ENDORSEMENT APPLICANTS ONLY:

Have you ever had a DEA number? YES NO If yes, please provide a copy of current DEA registration and list all numbers ever used _____

Has DEA registration ever been denied, limited, suspended, or revoked? YES NO (If yes, submit all relevant documents.)



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1123 SOUTH UNIVERSITY AVENUE
LITTLE ROCK, ARKANSAS 72204-1619
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www.arsbn.org

RE: Prescriptive Authority – DEA Registration Instructions

An advanced practice nurse with prescriptive authority must obtain a DEA registration number to prescribe controlled substances (schedule III, IV & V only.)

- A. APNs holding a Certificate of Prescriptive Authority may contact the New Orleans office of the DEA to receive an application for a DEA registration number. The toll free phone numbers are: 888.514.7302 or 888.514.8051. The DEA now has forms online for registration of advanced practice nurses. The application form can be found on the web at the Diversion Control Program website, www.DEAdiversion.usdoj.gov. At the website, select “Drug Registration,” then “Registration Applications.” The form is available in PDF format. It is necessary to have Adobe Acrobat or Adobe Acrobat Reader to access the form. There are two versions of the form available: (1) An online form. This version allows the user to complete the form online and submit. It is much quicker. The form can then be signed and mailed to the DEA; and (2) A blank form. This version can only be printed and completed manually. This version is not recommended because fewer errors occur if the form is completed online and then printed.
- B. When completing the DEA registration application you should:
 1. Enter your advanced practice license number (not your Certificate of Prescriptive Authority number.) You do not have a state controlled substance number.
 2. Indicate that you may prescribe, administer, dispense or procure Schedule III, IV and V narcotic and non-narcotic substances.
 3. You may as a nurse administer Schedule II drugs.
- C. The *ASBN Rules* require that you send a copy of your DEA number for your file. Please send the copy by fax to 501.686.2714 (please rewrite number if it is not legible) or by mail to:

Arkansas State Board of Nursing
1123 South University, Suite 800
Little Rock, AR 72204

The Pharmacy Services of the Arkansas Department of Health is responsible for enforcing the Controlled Substances Act. A copy of the *Rules and Regulations Pertaining to Controlled Substances* and the *List of Controlled Substances for the State of Arkansas* may be obtained by phone at 501.661.2325 or by mail at Arkansas Department of Health Pharmacy Services, 4815 West Markham, Slot 25, Little Rock, AR 72205.

Prescriptive authority may be terminated by the Board of Nursing for failure to maintain current active APN licensure or violation of any state or federal law or regulation applicable to prescriptions.

If you have any questions, please contact us. Pharmacists may contact us to verify prescriptive authority or for any other information related to the new law and regulations.

COLLABORATIVE PRACTICE AGREEMENT

This agreement is for the management of the collaborative practice between _____, APN and _____, MD. The physician hereby agrees to be available to the advanced practice nurse for consultation and referral. Mutually agreed upon protocols for prescriptive authority will be utilized by the APN as a guide for general categories of health states. The APN shall limit prescribing to area of educational preparation and certification as noted below.

Should an emergency arise, necessitating the absence of the advanced practice nurse or the collaborating physician from patient care responsibilities, provision for comparable coverage shall be arranged at the first possible opportunity. Until that time _____ (hospital) with which the collaborating providers are associated, provides emergency services twenty-four hours daily for the clients of _____ (clinic)

The review of practice may occur both informally, concurrent with case management and formally, through a retrospective program of quality assurance.

This agreement of professional collaboration is by no means intended as a business contract but rather as a document fulfilling the requirements for prescriptive authority as set forth in the *Arkansas Nurse Practice Act*. The signatures below signify mutual agreement to the terms of the collaborative practice.

_____, APN
Signature
Print name _____
Practice Site _____
Name of Business
Date _____

APN License # _____
Area of Certification _____
Practice Address _____
Street
City County Zip
Phone Number _____

_____, MD
Signature
Print name _____
Practice Site _____
Name of Business
Date _____

AR License # _____
Specialty _____
Address _____
Street
City County Zip

Practice site is same as APN

COLLABORATIVE PRACTICE AGREEMENT

with multiple physicians

This agreement is for the management of the collaborative practice between

_____, APN and _____, MD;
 _____, MD; _____, MD;
 _____, MD; _____, MD;

One of the physicians hereby agrees to be available to the advanced practice nurse for consultation and referral at all times. Mutually agreed upon protocols for prescriptive authority will be utilized by the APN as a guide for general categories of health states. The APN shall limit prescribing to area of educational preparation and certification as noted below.

Should an emergency arise, necessitating the absence of the advanced practice nurse, one of the collaborating physicians will cover the patient care responsibilities.

The review of practice may occur both informally, concurrent with case management and formally, through a retrospective program of quality assurance.

This agreement of professional collaboration is by no means intended as a business contract but rather as a document fulfilling the requirements for prescriptive authority as set forth in the *Arkansas Nurse Practice Act*. The signatures below signify mutual agreement to the terms of the collaborative practice.

_____, APN
Signature
 Print name _____
 Practice Site _____
Name of Business
 Date _____

APN License # _____
 Area of Certification _____
 Practice Address _____
Street

City County Zip
 Phone Number _____

_____, MD
Signature
 Print name _____
 Employment site _____
Name of Business
 Date _____

AR License # _____
 Specialty _____
 Address _____
Street

City County Zip

Practice site is same as APN

NOTE: If there are more than five (5) collaborating physicians, please complete additional collaborative practice agreement.

COLLABORATIVE PRACTICE AGREEMENT

with multiple physicians

Page 2 of 2

_____, MD
Signature

Print name _____

Employment Site _____
Name of Business

Date _____

Practice site is same as APN

AR License # _____

Specialty _____

Address _____
Street

City County Zip

_____, MD
Signature

Print name _____

Employment Site _____
Name of Business

Date _____

Practice site is same as APN

AR License # _____

Specialty _____

Address _____
Street

City County Zip

_____, MD
Signature

Print name _____

Employment Site _____
Name of Business

Date _____

Practice site is same as APN

AR License # _____

Specialty _____

Address _____
Street

City County Zip

_____, MD
Signature

Print name _____

Employment Site _____
Name of Business

Date _____

Practice site is same as APN

AR License # _____

Specialty _____

Address _____
Street

City County Zip

NOTE: If there are more than five (5) collaborating physicians, please complete additional collaborative practice agreement.

Documentation/Verification of Preceptorship in the Prescription of Drugs, Medicines, and Therapeutic Devices

(Must be on company or physician letterhead)

DATE: _____

TO: Arkansas State Board of Nursing

I confirm that _____, APN, has completed 300 hours of practice in the prescription of drugs, medicines, and therapeutic devices under my preceptorship. He/she started the pharmacology course on _____
date and started the preceptorship with me on _____
date and completed it on _____
date

He/she is recommended for prescribing privileges.

Sincerely,

Name
Title