

# 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](http://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. 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.)
  - f. Arkansas medical license number and specialty of collaborating physician;
  - g. Work site name(s), address(es) and phone number(s);
  - h. Collaborating physician's work site address (if different from your work site); and
  - i. Statement that APN will limit prescribing to area of educational preparation and certification.
5. Quality Assurance Plan to be submitted with the collaborative practice agreement. Go to ASBN Web site, [www.arsbn.org](http://www.arsbn.org), and click on "Advanced Practice" and locate Quality Assurance Guidelines for APNs.
6. 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.**

FALSIFICATION OF THIS FORM IS GROUNDS FOR DISCIPLINARY ACTION AGAINST YOUR LICENSE.

# ARKANSAS STATE BOARD OF NURSING

UNIVERSITY TOWER BUILDING  
1123 SOUTH UNIVERSITY, SUITE 800  
LITTLE ROCK, ARKANSAS 72204  
501.686.2700 • 501.686.2714 fax • www.arsbn.org

FOR OFFICE USE ONLY

## 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 No. \_\_\_\_\_ E-mail address \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

Birthdate \_\_\_\_\_ RN License # \_\_\_\_\_ APN License # \_\_\_\_\_  
Month/Day/Year

Practice Setting Name \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

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, pled guilty or nolo contendere to any charge in any state or jurisdiction? DWI's and similar offenses must be reported. (Traffic violations do not constitute a crime.) YES  NO   
(If yes, please include a copy of the court docket, plea agreement, or conviction papers, and evidence that fines, restitution are paid.)

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.)

FOR OFFICE USE ONLY  
Certificate Number \_\_\_\_\_  
Date Issued \_\_\_\_\_

**Certificate of Prescriptive Authority \$150.00**

**METHOD OF PAYMENT**

- In-state personal check
- Money order/cashiers check
- Credit card

**FEE IS NONREFUNDABLE**

**CREDIT CARD INFORMATION**

Complete below if paying by credit card. There is a nominal processing fee (listed below) assessed with paying your fees by credit card. The Arkansas State Board of Nursing does not receive any portion of the processing fee.

Type of card      Visa     MasterCard     Discover

Cardholder's Name \_\_\_\_\_

Cardholder's billing address \_\_\_\_\_

Credit Card # \_\_\_\_\_

Expiration date         /                           Amount Paid \_\_\_\_\_  
                                 mm      /      yyyy

Signature \_\_\_\_\_

\*Processing fee - Certificate of Prescriptive Authority - \$4.50

---

**AFFIDAVIT**

State of \_\_\_\_\_

County of \_\_\_\_\_

If, after a certificate has been issued on this application, it is ascertained that misrepresentation of facts or fraudulent statements have been made, the certificate so issued shall be revoked by the Board of Nursing and the applicant becomes subject to legal prosecution

I, \_\_\_\_\_, being duly sworn or affirmed, say that I am the person referred to in the foregoing application for a certificate of prescriptive authority in the State of Arkansas that the statements herein contained are true in every respect; that I agree to comply with all requirements of the law, including all state and federal laws and regulations regarding prescribing; and that I have read and understand this affidavit.

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_  
My Commission Expires \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

NOTARY  
SEAL

\_\_\_\_\_  
SIGNATURE \_\_\_\_\_, Notary Public

# Arkansas State Board of Nursing

University Tower Building  
1123 South University Avenue, Suite 800  
Little Rock, Arkansas 72204  
Telephone 501.686.2700  
Fax 501.686.2714  
[www.arsbn.org](http://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. Do not apply for the DEA registration prior to being issued Prescriptive Authority. 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 web site: [www.DEAdiversion.usdoj.gov](http://www.DEAdiversion.usdoj.gov). At the website, select "New 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 on-line and submit. It is much quicker. The form can then be signed and mailed to the DEA. You must have a credit card to pay the fee.
  2. A paper form can be requested. Call the above number and request form to be mailed to you.

Common questions concerning controlled substance applications are answered in the "Frequently Asked Questions" section of the web site, or applicants can contact the Registration Call Center at 800.882.9539.

- 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.
- 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 S. 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, 501.661.2325, or mail to:

Arkansas Dept. 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.

# 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](http://www.arsbn.org)

## Collaborative Practice Agreement

A current Collaborative Practice Agreement shall be on file with the Board of Nursing for each advanced practice nurse with active prescriptive authority. The APN must notify the Board in writing the first business day after the collaborative Practice Agreement is terminated. The APN is responsible for ensuring this requirement is met. Prescriptive authority is inactivated at that time. When a new Collaborative Practice Agreement has been approved by Board staff, prescriptive authority is reactivated.

The Collaborative Practice Agreement must meet the following criteria:

1. Must be legible and the **original** document;
2. The collaborating physician must have an Arkansas license to practice under Medical Practice Act, Section 17-93-201;
3. Physician's practice must be comparable in scope, specialty, or expertise to that of the APN;
4. Must include a statement that "APN's prescribing will be limited to area of specialty certification;
5. Provision addressing availability of physician for consultation or referral;
6. Method of management of the collaborative practice (include statement regarding protocols for prescriptive authority);
7. Plan for coverage of clients (where patients go) in the event of the absence of the APN;
8. Plan for coverage of clients (who APN will consult with) in the event of absence of the physician;
9. Quality Assurance Plan
10. Signature of the APN;
11. Signature of the physician(s);
12. If signatures are on a separate sheet from the agreement, a statement that signatures indicate mutual agreement to the terms and conditions of the collaborative practice agreement at the top of the second page;
13. Address and phone number of APN and physician(s) practice site(s);
14. License numbers and certification or specialty of APN and physician(s)

SEE FOLLOWING PAGES FOR EXAMPLES OF COLLABORATIVE PRACTICE AGREEMENTS THAT MEET THE ASBN'S CRITERIA

# COLLABORATIVE PRACTICE AGREEMENT

(Use if you are collaborating with a single physician - physician and back-up physician must sign)

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, either in person or via electronic or telephonic communication, 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)

There is a written provision for quality assurance (attach Quality Assurance Plan).

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 \_\_\_\_\_  
Practice Address \_\_\_\_\_  
Street  
City County Zip

Practice site is same as APN

**The physician below agrees to be available to \_\_\_\_\_ , APN, for consultation and referral in the absence of the collaborating physician.**

\_\_\_\_\_, MD  
Signature  
Print name \_\_\_\_\_  
Practice Site \_\_\_\_\_  
Name of Business  
Date \_\_\_\_\_

Specialty \_\_\_\_\_  
AR License # \_\_\_\_\_  
Practice Address \_\_\_\_\_  
Street  
\_\_\_\_\_  
City County Zip

# 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, either in person or via electronic or telephonic communication, 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.

There is a written provision for quality assurance (attach Quality Assurance Plan).

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 \_\_\_\_\_  
Practice 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 \_\_\_\_\_

Practice Address \_\_\_\_\_  
Street

\_\_\_\_\_  
City County Zip

\_\_\_\_\_, MD  
Signature

Print name \_\_\_\_\_

Employment Site \_\_\_\_\_  
Name of Business

Date \_\_\_\_\_

Practice site is same as APN

AR License # \_\_\_\_\_

Specialty \_\_\_\_\_

Practice Address \_\_\_\_\_  
Street

\_\_\_\_\_  
City County Zip

\_\_\_\_\_, MD  
Signature

Print name \_\_\_\_\_

Employment Site \_\_\_\_\_  
Name of Business

Date \_\_\_\_\_

Practice site is same as APN

AR License # \_\_\_\_\_

Specialty \_\_\_\_\_

Practice Address \_\_\_\_\_  
Street

\_\_\_\_\_  
City County Zip

\_\_\_\_\_, MD  
Signature

Print name \_\_\_\_\_

Employment Site \_\_\_\_\_  
Name of Business

Date \_\_\_\_\_

Practice site is same as APN

AR License # \_\_\_\_\_

Specialty \_\_\_\_\_

Practice 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