

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 ENDORSEMENT APPLICATION

TO: Advanced Practice Nurse

You may be eligible to apply for a Certificate of Prescriptive Authority through endorsement. Please read the following information carefully.

REQUIREMENTS

1. You must have an unencumbered advanced practice nursing license to practice in Arkansas.
2. You must contact the Board of Nursing in the jurisdiction where you have prescribing privileges and have a notarized Advanced Practice Verification Form (form attached) completed by and sent directly from the Board of Nursing in the jurisdiction where you have current prescribing privileges. You probably have already completed this form when you applied for your advanced practice license.
3. You must submit documentation of a three (3) graduate credit hour pharmacology course offered by an accredited college or university or a forty-five (45) contact hour (a contact hour is fifty (50) minutes) pharmacology course which includes a competency component offered by an accredited college or university.
4. You must submit notarized evidence of a minimum of five hundred (500) hours of **prescribing** in a clinical setting in the year prior to application.
5. You must submit an original, current collaborative practice agreement (sample attached) with an Arkansas licensed physician who has a practice comparable in scope, specialty or expertise to yours. The collaborative practice agreement shall include, but not be limited to:
 - a. Availability of the collaborating physician(s) for consultation or referral, or both;
 - 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 (with whom an APN will consult) 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.
6. You must submit a copy of current DEA registration and a list of DEA numbers used (if prescriber has DEA number) and history of registration status.
7. Quality Assurance Plan to be submitted with the collaborative practice agreement. Go to ASBN Web site, www.arsbn.org, and click on "Advanced Practice" and locate Quality Assurance Guidelines for APNs.
8. 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

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LITTLE ROCK, ARKANSAS 72204
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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

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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 _____ with which the collaborating providers are associated, provides emergency services twenty-four hours daily for the clients of _____.

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.

**MUST BE ON COMPANY
OR PHYSICIAN LETTERHEAD**

FROM: _____

DATE: _____

TO: ARKANSAS STATE BOARD OF NURSING

THIS LETTER IS TO PROVIDE EVIDENCE THAT _____, APN
(print name)

HAS COMPLETED A MINIMUM 500 HOURS PRESCRIBING IN A CLINICAL SETTING IN THE YEAR IMMEDIATELY
PRIOR TO APPLICATION FOR PRESCRIPTIVE AUTHORITY.

DATE LAST WORKED

SIGNATURE OF PHYSICIAN OR EMPLOYER

(print name)

NOTARY SEAL

**NOTE: THIS FORM IS ONLY FOR ADVANCED PRACTICE APPLICANTS SEEKING ENDORSEMENT OF
THEIR PRESCRIPTIVE AUTHORITY FROM ANOTHER JURISDICTION.**