



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 should 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. 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.
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. 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.)

METHOD OF PAYMENT:

- Credit Card Money Order/Cashiers Check
- In-state personal check

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 .

Signature _____

*Processing fee - Certificate of Prescriptive Authority Application - \$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.

Applicant's Signature

Sworn to before me this _____ day of _____, 20 _____

My Commission Expires _____, 20 _____

NOTARY
SEAL

SIGNATURE, Notary Public

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 _____ 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

**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 # _____

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 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.

**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.**