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.


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.
CERTIFICATE OF PRESCRIPTIVE AUTHORITY APPLICATION

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

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 Zip Code

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? YES NO
(DWI's and similar offenses must be reported. (Traffic violations do not constitute a crime.)
(If yes, include a certified copy of the court docket, plea agreement, or conviction papers, and evidence that fines, restitution are paid.)

Have you ever had any license, certificate, registration, or privilege to practice 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.)

(over)
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

My Commission Expires __________________________, 20____

__________________________________________, Notary Public

FEE IS NONREFUNDABLE
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.DEAdi version.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.
Collaborative Practice Agreement with a Single Physician

Advanced Practice Nurses (APNs) with Prescriptive Authority must have a current updated Collaborative Practice Agreement (CPA) on file with the Board of Nursing. APNs should keep their original CPA and provide the Board with a copy submitted via fax, mail, or scanned/emailed. The APN is responsible for ensuring this requirement is met.

The APN must notify the Board in writing the first business day after the CPA is terminated. If the Board does not have a current CPA on file, the APN’s Prescriptive Authority will be inactivated. When a new CPA has been approved by Board staff, Prescriptive Authority is reactivated. After approval of any new CPA, the APN will be contacted by mail that the CPA has been approved and in effect.

The Collaborative Practice Agreement must meet the following criteria:

1. Must be complete and legible
2. The collaborating physician must have a current AR license to practice under the Medical Practice Act, § 17-95-201. The collaborating physician must also have an unrestricted DEA registration number for APNs who prescribe controlled substances.
3. The collaborating physician’s practice must be comparable in scope, specialty, or expertise to that of the APN’s practice/specialty.
4. Must include a statement that “APN’s prescribing will be limited to the area of educational preparation and certification.”
5. Provision addressing availability of the collaborating physician for consultation and/or referral
6. Method of management of the collaborative practice (include a statement regarding protocols for Prescriptive Authority)
7. Plans for coverage of the health care needs of the patient in the emergency absence of the APN or collaborating physician
8. Provision for quality assurance (attach the Quality Assurance Plan that has been signed by the APN and the collaborating physician).
9. Signatures of both the APN and the collaborating physician
10. If signatures are on a separate sheet from the agreement, a statement indicating that there is mutual agreement to the terms and conditions of the CPA must be included on the signature page (so that it is clear what the signature indicates).
11. License numbers and certification specialties of both the APN and the collaborating physician
12. Address and phone number of the APN’s and physician’s practice site(s)

See the next page for an example of a Collaborative Practice Agreement that meets the ASBN’s criteria. If you choose to list more than one physician, please use the “Collaborative Practice Agreement with Multiple Physicians” document.
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 collabora-
ting 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
Print name ____________________________
Practice Site __________________________
Name of Business ______________________
Date _________________________________

_________________________________, MD
Print name ____________________________
Practice Site __________________________
Name of Business ______________________
Date _________________________________

☐ 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
Print name ______________________________________
Practice Site __________________________ Name of Business
Date ______________________________________

Specialty ______________________________
AR License # _________________________
Practice Address _______________________ Street
City __________________ County ______ Zip

Page 2 of 2
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
Print name ______________________________________________
Practice Site __________________________ Name of Business
Date __________________________

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

_________________________________________, MD
Print name ______________________________________________
Employment site __________________________ Name of Business
Date __________________________

AR License # __________________________
Specialty __________________________
Practice Address __________________________ Street

_________________________________________, MD
Print name ______________________________________________
Practice Address __________________________ Street

Phone Number __________________________

City County Zip

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.
NOTE: If there are more than five (5) collaborating physicians, please complete additional collaborative practice agreement.
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 ___________________________ and started the preceptorship with me on ___________________________ and completed it on ___________________________.

He/she is recommended for prescribing privileges.

Sincerely,

Name
Title