PENNSYLVANIA STATE BOARD OF NURSING
P.O. BOX 2649
HARRISBURG, PA 17105-2649

PHONE (717) 783-7142
FAX (717) 783-0822
www.dos.pa.gov/nurse
Email: st-nurse@pa.gov

Instructions
For Certified Registered Nurse Practitioner (CRNP) Prescriptive Authority Application

To prescribe and dispense drugs in Pennsylvania you must have an active Pennsylvania RN license, an active Pennsylvania CRNP Certificate and an active Pennsylvania Prescriptive Authority Approval.

FAQs AND LAW/REGULATIONS

- FAQs about Prescriptive Authority as well as the Professional Nursing Law and the Board's regulations can be found on the Board's website at www.dos.pa.gov/nurse .

INSTRUCTIONS:

- Mail the completed application and fee to the Board at the above address.
- All questions must be answered completely and all fees submitted in order for the application to be processed.
- To verify that the CRNP Prescriptive Authority was issued visit **www.pals.pa.gov/verify**.
- Social Security Numbers must be provided.* If a Waiver of Social Security Number form is submitted in lieu of a Social Security Number, it cannot be used to renew a CRNP Prescriptive Authority.
- Application must be received in the Board office within 90 days from the date the affidavit is signed.
- Applications are valid for one year from the date the affidavit is signed.
- If a CRNP Prescriptive Authority is not issued within the one year, a new application, including fees, must be submitted.

FEES:

- The $50.00 Initial Application and/or $30.00 Additional Authority Application fee must be paid by personal check, cashier's check or money order and must be made payable to the **"Commonwealth of Pennsylvania."**
- **Fees are nonrefundable**.
- Check/money orders drawn on foreign banks are only acceptable when "US funds" is identified on the check/money order.
- A $20.00 processing fee will be charged for a check/money order returned unpaid. Applications will not be processed until the corrected fee is received.

NAME / ADDRESS:

- Applicant's legal name must be entered on the application.
- A CRNP Prescriptive Authority is not forwarded.
- Complete and submit the "Request Change of Name and/or Address …" located on the Board's website, whenever there is a change of name and/or address.
- Licensees are responsible to advise the Board of any address or name change within 14 days of the change.

QUESTIONS: *If "YES" was checked for any questions in Section B, submit:*

- A detailed, signed and dated personal explanation explaining the action, its background and any rehabilitation.
- A Criminal History Records Check (CHRC) from a State Law Enforcement Authority in all states where you lived in the last five years. All background check documents cannot be older than 90 days from the date of issuance. (Applicable ONLY to #B4 and #B5)
- Copies of criminal Court documents. (Applicable ONLY to #B4 and #B5)
- Certified copies of all disciplinary actions from the Boards that imposed action (Applicable ONLY to #B1 ,#B2 and #B3).

CONTINUING EDUCATION:

- Out of the 30 total hours, CRNPs with Prescriptive Authority must complete at least 16 hours of Board-approved continuing education in pharmacology in the 2-year period immediately preceding biennial renewal and 2 hours of continuing education in pain management, or the identification of addiction, or the practice of prescribing, or dispensing of opioids.
- As part of the biennial renewal application CRNPs are required to verify completion of the pharmacology and opioid education hours.
- Refer to www.dos.pa.gov/nurse for detailed information about this continuing education renewal requirement.

Application Submission Requirements:

Applicants for INITIAL CRNP Prescriptive Authority in Pennsylvania must submit:

- ☐ *An Application for CRNP Prescriptive Authority* signed by the applicant.
- ☐ *Collaborative Agreement for CRNP Prescriptive Authority* signed by the applicant and the collaborating physician. The original *Collaborative Agreement* must remain at the primary practice location.
- ☐ Evidence of Advanced Pharmacology and Opioid Education.
    - The Verification of Advanced Pharmacology Form verifies the number of hours/credits of advanced pharmacology course work, which includes evidence of the 4 hours of opioid education consisting of 2 hours of education in pain management or identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids. The 4 hours of Board-approved education needs to be completed once withinone year of issuance of the prescriptive authority approval.
        - If this information was included on the Verification of Nurse Practitioner Program Form, the Verification of Advanced Pharmacology does not need to be submitted.
    - *Verification of Opioid Education* completed and mailed to the Board by the Program Director, a Board-approved advanced pharmacology provider or the CRNP continuing education provider to be submitted within one year of issuance of the prescriptive authority approval. This verification does NOT NEED to be provided if the 4 hours of opioid education was verified as part of the CRNP education.
        - If this information was included on the Verification of Nurse Practitioner Program Form or the Verification of Advanced Pharmacology Form this form does not need to be submitted.
- ☐ A **$50** fee for Initial Application.

Applicants for ADDITIONAL CRNP Prescriptive Authority in Pennsylvania must submit:

- ☐ *An Application for CRNP Prescriptive Authority* signed by the applicant.
- ☐ A copy of the *Collaborative Agreement for CRNP Prescriptive Authority* signed by the applicant and collaborating physician. The original *Collaborative Agreement* must remain at the primary practice location.
- ☐ *Verification of Opioid Education* completed and mailed to the Board by the Program Director, a Board-approved advanced pharmacology provider or the CRNP continuing education provider to be submitted within one year of issuance of the prescriptive authority approval. This verification does NOT NEED to be provided if the 4 hours of opioid education was verified as part of the CRNP education.
- ☐ A **$30** fee for each additional *CRNP Application for Prescriptive Authority Application*
  ***Note**: An applicant for an ADDITIONAL Prescriptive Authority is applying for a NEW agreement with a NEW collaborating physician. A CRNP may hold multiple prescriptive authority approvals at the same time, each with a different collaborating physician but only has to obtain the 4 hours of opioid education once.

APPLICATION FOR CRNP PRESCRIPTIVE AUTHORITY:

- Include the Pennsylvania CRNP Certificate number on the prescriptive authority application (this begins with **SP-, VP-, TP-, or UP-).** Prescriptive authority cannot be granted to a CRNP applicant whose application has a "Pending" status.
- The National Certification Number is not required on this application.
- The application must include the Applicant's original signature and date signed; faxed, emailed, or scanned copies will not be accepted.

COLLABORATIVE AGREEMENT FOR CRNP PRESCRIPTIVE AUTHORITY:

- Print the CRNP specialty **exactly as listed** on the Pennsylvania CRNP Certificate. Specialties should be verified at www.licensepa.state.pa.us.
    - Professional liability insurance—simply answer the question; **do not attach the insurance policy**.
- Collaborative/Substitute Physician
    - **Collaborative and substitute physicians must hold active Pennsylvania licenses.**
    - Ensure that collaborating and substitute physicians' names and license numbers are correct by verifying the information at www.pals.pa.gov/verify.
    - **Include the entire license number (**prefixes/suffixes and zeros are part of a license number). **Include at least one substitute physician. Applications without a substitute** cannot be processed,
    - If th**ere are multiple substitute physicians, check "List of additional substitutes** is attached" and attach the list with each physician's name and license numbers**.** The CRNP and collaborating physician **must** be listed at the top of the attachment.

- Controlled Substance Prescribing Authority
  - Complete for each Schedule even if specific Schedules are not permitted.
  - List the day supply amount for each Schedule requested.
  - The maximum day supply amounts currently permitted by regulation are:
    Schedule II = 30 day supply Schedule III = 90 day supply Schedule IV = 90 day supply
- Make available, upon request, the original *Collaborative Agreement for CRNP Prescriptive Authority* at the primary practice location. A copy of the *Collaborative Agreement* should be maintained by the CRNP.
- A CRNP may not prescribe until the Prescriptive Authority Application is approved by the Board.

ADVANCED PHARMACOLOGY:

- The applicant must have successfully completed a minimum of 45 hours/3 credits of course work specific to advanced pharmacology within 5 years of the date the applicant applies for initial prescriptive authority approval. If the course was completed beyond 5 years of the date the applicant applied for initial prescriptive authority, the applicant must submit evidence of prescriptive authority issued in another jurisdiction.
- The Verification must be completed by the program director where the Advanced Pharmacology course was taken listing the number of hours of advanced pharmacology content, including the 4 hours of opioid education, and the specialty completed.

OPIOID EDUCATION:

- The applicant must have completed a minimum of 4 hours of Board-approved education consisting of 2 hours of education in pain management or identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids. Additional information is available at www.dos.pa.gov/nurse.

* Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

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APPLICATION FOR CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) PRESCRIPTIVE AUTHORITY

ALL FEES ARE NONREFUNDABLE

Applying For: (Check only one.)

☐ ***Initial*** **Application for** CRNP **Prescriptive Authority in PA ($50.00)**

☐ ***Additional*** **Application for** CRNP **Prescriptive Authority in PA ($30.00)**

SECTION A: APPLICANT INFORMATION: (Print clearly in dark blue or black ink or type.)

Name: _____
Last First Middle

Date of Birth: _____ U.S. Social Security Number*: _____
Month Day Year

Address: _____
Street

_____
City State Zip

(_____)_____ Email Address: _____
Daytime Phone #

Pennsylvania CRNP Number_____

SECTION B: QUESTIONS: ANSWER THE FOLLOWING QUESTIONS.

		YES*	NO
1.	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
2.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3.	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
4.	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		

Name: _____ **SSN:** _____

		YES	NO
5.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
6.	Do you currently engage in, or have you ever engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
7.	Have you ever had your DEA registration denied, revoked or restricted?		
8.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
9.	Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?		
10.	Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		

SECTION C: AFFIDAVIT: READ, SIGN AND DATE. ALL APPLICANTS MUST COMPLETE THIS SECTION.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Applicant's Full Legal Signature _____ Date _____

*Note that disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

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COLLABORATIVE AGREEMENT FOR CRNP PRESCRIPTIVE AUTHORITY

1) **Name of Certified Registered Nurse Practitioner:** _____

Pennsylvania CRNP Number: _____

CRNP Specialty exactly as listed on the Pennsylvania CRNP Certificate **:** _____

Professional Liability: Check one

- ☐ I maintain the required professional liability insurance.
- ☐ I am exempt from having the required professional liability insurance.

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2) **Collaborating Physician:** Name: _____

Pennsylvania License Number: _____
(Include prefix/suffix)

Substitute Physician: Name**:** _____ ☐ List of additional substitutes is attached
(At least one (1) substitute physician is required.)

Pennsylvania License Number: _____
(Include prefix/suffix)

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3) **Indicate the circumstances, and how often the collaborating physician will personally see the patient. (Must check at least one.)**

- ☐ Once per year
- ☐ Twice per year
- ☐ Daily
- ☐ Every other visit
- ☐ CRNP Request
- ☐ Patient or Family request
- ☐ Patient not responding to treatment
- ☐ Patient condition outside CRNP scope of practice
- ☐ Other _____

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4) **Controlled Substance Prescribing Authority: (Check YES or NO for each Schedule.)**

Schedule II

- ☐ Yes, I am requesting **Schedule II** for up to a _____ day supply
- ☐ No

Schedule III

- ☐ Yes, I am requesting **Schedule III** for up to a _____ day supply
- ☐ No

Schedule IV

- ☐ Yes, I am requesting **Schedule IV** for up to a _____ day supply
- ☐ No

COLLABORATIVE AGREEMENT FOR PRESCRIPTIVE AUTHORITY (continued)

Name of Certified Registered Nurse Practitioner: _____

Pennsylvania CRNP Number: _____

5) Drug Categories: Individually check each category of drugs from which the CRNP may prescribe and dispense. The box must be **blank** if you are not selecting the category. **Do not alter any category box.**

	(a) Antihistamines
	(b) Anti-infective agents
	(c) Antineoplastic agents
	(d) Unclassified therapeutic agents
	(e) Devices and pharmaceutical aids
	(f) Autonomic drugs
	(g) Blood formation drugs
	(h) Coagulation and anticoagulation drugs
	(i) Thrombolytic and antithrombolytic agents
	(j) Cardiovascular drugs
	(k) Central nervous system agents
	(l) Contraceptives including foams and devices
	(m) Diagnostic agents
	(n) Disinfectants for agents used on objects other than skin
	(o) Electrolytic, caloric and water balance
	(p) Enzymes
	(q) Antitussive, expectorants and mucolytic agents
	(r) Gastrointestinal drugs
	(s) Local anesthetics
	(t) Eye, ear, nose and throat preparations
	(u) Serums, toxoids and vaccines
	(v) Skin and mucous membrane agents
	(w) Smooth muscle relaxants
	(x) Vitamins
	(y) Hormones and synthetic substitutes

6 The date you are requesting that this agreement become effective: _____
(mm/dd/yyyy)

This Collaborative Agreement for Prescriptive Authority contains the details regarding the prescribing and dispensing of drugs between the following parties:

_____
Signature of CRNP Date Signed (mm/dd/yyyy)

Signature of Collaborating Physician Date Signed (mm/dd/yyyy)

State Board of Nursing
2601 North Third Street
Harrisburg PA 17110

State Board of Nursing
P O BOX 2649
Harrisburg PA 17105-2649

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

VERIFICATION OF ADVANCED PHARMACOLOGY

APPLICANT INFORMATION

NAME:	Last	First	Middle
OTHER NAME(S):			
DATE OF BIRTH:		**LAST 4 DIGITS OF SSN:**	
ADDRESS:			
CITY / STATE / ZIP:			

NP PROGRAM / BOARD-APPROVED ADVANCED PHARMACOLOGY COURSE INFORMATION

NAME OF PROGRAM / PROVIDER:	
CITY / STATE:	
PRINT NAME OF DIRECTOR / PROVIDER:	
DIRECTOR / PROVIDER'S PHONE NUMBER:	
EMAIL ADDRESS OF DIRECTOR / PROVIDER:	

The following information must be completed by the Director of the NP Program or a Board-approved advanced pharmacology course provider and must verify that the applicant successfully completed at least 45 hours / 3 credits of course work in advanced pharmacology and if the course included 4 hours of opioid education. NOTE: If the advanced pharmacology content was incorporated into more than one course, provide all course numbers and completion dates.

I hereby certify that the above-listed applicant has successfully completed at least 45 hours / 3 credits of ADVANCED PHARMACOLOGY as part of the _____ Nurse Practitioner Program.

(Specialty)

This course included 2 hours of education in pain management or the identification of addiction. YES _____ NO _____

This course included 2 hours of education in the practices of prescribing or dispensing of opioids. YES _____ NO _____

Course Number(s):	
Completion Date(s):	

I verify that the above statements are true and correct as validated by my review of the applicant's school records. I verify that the information communicated on this form is true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsification to authorities.

Original Signature of Program Director / Provider:		DATE:	Month:	Day:	Year:

(School Seal)

MAIL <u>DIRECTLY</u> TO THE STATE BOARD OF NURSING IN AN OFFICIAL SCHOOL ENVELOPE TO P.O. BOX 2649, HARRISBURG, PA 17105-2649.

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BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

VERIFICATION OF OPIOID EDUCATION

APPLICANT INFORMATION

NAME:	Last	First	Middle
OTHER NAME(S):			
DATE OF BIRTH:		**LAST 4 DIGITS OF SSN:**	
ADDRESS:			
CITY / STATE / ZIP:			

NP PROGRAM / ADVANCED PHARMACOLOGY COURSE PROVIDER / CE PROVIDER INFORMATION

NAME OF PROGRAM/PROVIDER:	
ADDRESS:	
CITY / STATE / ZIP:	
PRINT NAME OF DIRECTOR / PROVIDER:	
PHONE NUMBER:	
EMAIL ADDRESS OF DIRECTOR / PROVIDER:	

The following information must be completed by the Director of the NP Program, a Board-approved advanced pharmacology course provider, or the Board-approved continuing education provider and must verify that the applicant successfully completed at least 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids.

I hereby certify that the above-listed applicant successfully completed 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids on

_____/_____/_____.

Month Day Year

I verify that the above statements are true and correct as validated by my review of the applicant's records. I verify that the information communicated on this form is true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsification to authorities.

Original Signature of Director / Provider:		DATE:	Month	Day	Year

RETURN THIS FORM TO THE STATE BOARD OF NURSING VIA FAX: 717-783-0822, MAIL: PO BOX 2649, HARRISBURG, PA 17105 OR EMAIL: ST-NURSE@PA.GOV.