**Oklahoma Board of Nursing**
**2915 N. Classen Blvd., Suite 524**
**Oklahoma City, OK 73106**
**(405) 962-1800**
**www.nursing.ok.gov**

***Agreement for Physician Supervising Advanced Practice Prescriptive Authority***

***Once completed, this Agreement is to be uploaded through your Nurse Portal Account.***
***No fee accompanies this form.**

**This *Agreement* is NOT needed if the APRN is working in a VA facility , has submitted written verification that VA has granted full practice authority, AND is NOT prescribing Controlled Dangerous Substances (38 C.F.R. § 17.415). Please type or use blue or black ink to complete the form. Do not use correction fluid.**

**Part I: To Be Completed by the Advanced Practice Registered Nurse**

1. Name (as it appears on license)_____

2. OK License Number_____

3. Role of advanced practice license held in OK (Check one) ___CNP _____ CNS _____CNM

4. Specialty of Advanced Practice License held in OK_____

5. **Purpose for Submission** of *Agreement for Physician Supervising Advanced Practice Prescriptive Authority* (**Check One**):
   - ____ Addition of a physician (upload the *Agreement* once you have submitted the *Change of Supervising Physician* form and fee found your Nurse Portal account)
   - ____ Application for prescriptive authority (upload the *Agreement* once the application and its fee are submitted via your Nurse Portal account)
   - ____ Renewal of prescriptive authority (submit the *Agreement* after completing the renewal in your Nurse Portal account)
   - ____ Reinstatement of prescriptive authority (upload the *Agreement* once the reinstatement application and its associated fee are submitted via your Nurse Portal account)

**Part II: To Be Completed By the Physician**

1. Physician Name _____ MD / DO
   First Middle Initial Last (Circle One)

2. Oklahoma License Number _____ Expiration Date _____

3. Work Address _____
   Street City State Zip Telephone #

4. Practice Specialty Area _____ National Certification Board _____
   If not certified, write "none."

5. Do you have an unrestricted license from the Oklahoma Board of Medical Licensure and Supervision or from the Oklahoma State Board of Osteopathic Examiners? _____ Yes _____No

6. Do you have a current, unrestricted permit from:
   A. Oklahoma Bureau of Narcotics and Dangerous Drug Control? _____Yes _____No
   B. Drug Enforcement Agency (DEA)? _____Yes _____No

AFFIDAVIT

Supervision of Advanced Practice Registered Nurses with prescriptive authority means overseeing and accepting responsibility for the ordering and transmission of written, telephonic, electronic or oral prescriptions for drugs and other medical supplies, subject to a defined formulary [O.S. 567.3a(11) and (12)].

I, _____ agree to supervise the prescriptive authority practice of
Name of supervising physician

_____ effective _____. I further agree to be available for
Name of Advanced Practice Registered Nurse Date

consultation, collaboration, assistance with medical emergencies, and patient referral through direct contact, telecommunications or other appropriate electronic means. I am not in training as an intern, resident or fellow. I have reviewed the Exclusionary Formulary approved by the Oklahoma Board of Nursing. I agree to remain in compliance with the Rules and Regulations promulgated by the Oklahoma State Board of Medical Licensure and Supervision (for MDs) or Oklahoma State Board of Osteopathic Examiners (for DOs). Further, I certify that the statements contained in this Agreement are true and correct.

Signature of Physician _____ MD / DO
(Circle One)

Subscribed to and sworn before me, this _____ day of _____, 2_____.

_____ _____
Commission Expires Notary Public

(SEAL)