

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

**REQUEST FOR CHANGE IN PHYSICIAN(S) SUPERVISING
ADVANCED PRACTICE PRESCRIPTIVE AUTHORITY
(for the CNP, CNM, and CNS)**

EXCEPTION: APRN-CNPs, APRN-CNSs, and APRN-CNMs are not required to have a supervising physician if they are working ONLY at a Veterans Affairs (VA) facility, has submitted written verification that the VA has granted the APRN full practice authority, AND will NOT be prescribing Controlled Dangerous Substances.

Fee - \$10.00 per “Request for Change” form submitted

1. Application:

Complete and submit the *Request for Change in Physician(s) Supervising Advanced Practice Prescriptive Authority* and sign before a Notary Public for any changes (addition and/or deletion) of physician(s) supervising advanced practice prescriptive authority. The effective date for additions and/or deletions of supervising physicians must be completed.

- The change shall be filed with the Board within 30 days of the change and shall be effective upon filing [59 O.S. § 567.4a 1.].

2. Addition of Supervising Physician:

An Agreement for Physician Supervising Advanced Practice Prescriptive Authority (Form RS-20) must be completed and signed by each new supervising physician in front of a Notary Public. The *Agreement* must be submitted with the *Request for Change in Physician(s) Supervising Advanced Practice Prescriptive Authority*.

3. Deletion of Supervising Physician:

Clearly indicate the full name(s) of the supervising physician(s) to be deleted on the *Request for Change in Physician(s) Supervising Advanced Practice Prescriptive Authority*.

4. Fee

There is a fee of \$10.00 for each *Request for Change in Physician(s) Supervising Advanced Practice Prescriptive Authority form* submitted. On each form, you may add up to five physicians and/or delete up to five physicians. Please submit the payment in the form of a personal check, certified check or money order. Checks may be made payable to the Oklahoma Board of Nursing. If the fee is not submitted with the *Request* or if the fee is incorrect, the *Request* will be returned without review.

The *Request* will be processed within 8 days of receipt of the completed information into the Board office. After 8 days, you may verify the completion of the changes by using the Board’s website: www.nursing.ok.gov. Please click on the link for “License Verification” and enter your name or license number, then click on “APRN/RX” to view your current supervising physicians.

- Please note that the Advanced Practice Registered Nurse must hold a separate prescriptive authority recognition for each advanced practice license and for each advanced practice specialty certification.

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

***Request for Change in Physician(s) Supervising
Advanced Practice Prescriptive Authority***

Check One: CNP _____ CNM _____ CNS _____

RN License Number: _____

1. Name on license _____
First Middle or Maiden Last

2. Mailing address _____ () _____
Street City State Zip Telephone #

3. Work address _____ () _____
Street City State Zip Telephone #

4. Advanced practice specialty certification _____

5. National Certifying Body _____
Name of Certifying Body Date of Expiration of National Certification

6. Practice Setting (Hospital, Nursing Home, etc.) _____

7. Please **add** the following supervising physician(s):

Name Circle One MD/DO Effective Date

Name Circle One MD/DO Effective Date

Name Circle One MD/DO Effective Date

Name Circle One MD/DO Effective Date

Name Circle One MD/DO Effective Date

NOTE: ***An Agreement for Physician Supervising Advanced Practice Prescriptive Authority (Form RS-20) must be submitted for each new supervising physician.***

8. Please **delete** the following supervising physician(s):

_____	MD/DO	_____
Name	Circle One	Effective Date
_____	MD/DO	_____
Name	Circle One	Effective Date
_____	MD/DO	_____
Name	Circle One	Effective Date
_____	MD/DO	_____
Name	Circle One	Effective Date
_____	MD/DO	_____
Name	Circle One	Effective Date

NOTE: You must have at least one current supervising physician on file in order to maintain prescriptive authority. If you are deleting all supervising physicians and you are NOT adding a new physician, please note that you **must have** a supervising physician on file with the Board **prior** to prescribing drugs or medical supplies [OAC 485:10-16-5(b)].

PRESCRIPTIVE AUTHORITY AFFIDAVIT
(to be completed by the Advanced Practice Registered Nurse)

I certify that I am the licensee listed above and that the statements listed herein are true.

I agree to contact my physician supervising prescriptive authority, for collaboration and referral as appropriate in relationship to prescriptive practices. I also agree to comply with state and Federal Drug Enforcement Administration (DEA) requirements prior to prescribing controlled substances.

I further agree to notify the Board office of any changes in physicians supervising prescriptive authority in writing within 30 days of the change, which shall be effective upon filing.

Signature of Licensee: _____
(Do not print or use initials)

Date: _____

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

My Commission Expires

Notary Public

(STAMP SEAL ONLY)