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

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

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 or deletion) of physician(s) supervising advanced practice prescriptive authority.

- 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 of the supervising physician 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.ok.gov/nursing. 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.

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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	Effective Date
	MD/DO	
	MD/DO	
	MD/DO	
	MD/DO	
	MD/DO	

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):

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

NOTE: You must have at least one current supervising physician on file in order to maintain prescriptive authority.

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)