Oklahoma Board of Nursing
2501 N. Lincoln Blvd., Suite 207
Oklahoma City, OK 73105
(405) 962-1800
www.nursing.ok.gov

Agreement for Physician Supervising Advanced Practice Prescriptive Authority

Use this document for the following:

1. **Complete and upload to your Nurse Portal account for each current Supervising Physician when renewing prescriptive authority every two years.**

2. **Complete and upload when adding supervising physician(s) for previously granted prescriptive authority.**

    a. **You will upload this Form when adding a supervising physician during the submission of the "Request for Change in Physician(s) Supervising Advanced Practice Authority (for the CNP, CNM, and CNS)" as found in the Other Applications link through your Nurse Portal account and submit the required fee.**

    b. **Next, you upload a completed and notarized "Agreement for Physician Supervising Advanced Practice Prescriptive Authority" form.**

3. **Complete and upload Agreement(s) for all requested supervising physician(s) when submitting your application through your Nurse Portal account for initial or endorsed-in prescriptive authority recognition.**

4. **Complete and upload Agreement(s) for all supervising physicians during the submission of your application for Reinstatement of Prescriptive Authority recognition as found in your Nurse Portal account.**

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.

***Proceed to the next page to complete the *Agreement for Physician Supervising Advanced Practice Prescriptive Authority* document.**

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 (ex: Family; Neonatal)_____

5. **Purpose for Submission** of *Agreement for Physician Supervising Advanced Practice Prescriptive Authority*

(**Check One**):

___ **Addition of a physician for previously granted prescriptive authority** (upload the *Agreement* during submission of the *Change of Supervising Physician* form and fee as found in your Nurse Portal account)

___ **Application for prescriptive authority** (upload the *Agreement* during the submission of your application via your Nurse Portal account)

___ **Renewal of prescriptive authority** (upload the *Agreement* after completing the renewal in your Nurse Portal account)

____ **Reinstatement of prescriptive authority** (upload the *Agreement* during submission of the reinstatement application and its associated fee 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

***Continue to Affidavit on page 3.**

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)