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. Oklahoma Bureau of Narcotics and Dangerous Drugs Control (OBNDD)
   A. Do you have a current permit from the OBNDD? ___Yes ___No
   B. Do you have an unrestricted permit from the OBNDD? ___Yes ___No
   *If No, please describe the restriction(s): ____________________________________

7. Drug Enforcement Administration (DEA)
   A. Do you have a current permit from the DEA? ___Yes ___No
   B. Do you have an unrestricted permit from the DEA? ___Yes ___No
   *If No, please describe the restriction(s): ____________________________________

*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)