Agreement for Physician Supervising Advanced Practice Prescriptive Authority

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):
   ___ Application for prescriptive authority (submit the Agreement once the application and its fee are submitted on the Board’s website via the License Registration link)
   ___ Addition of a physician (submit the Agreement with Change of Supervising Physician form and fee found in the Forms / Applications link on the Board’s website)
   ___ Reinstatement of prescriptive authority (submit the Agreement once the reinstatement application and its associated fee are submitted on the Board’s website via the License Registration link)
   ___ Renewal of prescriptive authority (submit the Agreement after completing the renewal on the Board’s website in the License Renewal link)

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

Name of Advanced Practice Registered Nurse effective _____________. I further agree to be available for 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)