

Advanced Practitioner of Nursing (APN) - Dispense - Download application and mail to the address on the top of the application with the required \$300.00 fee and attachments. The fee is payable by check or money order only, we do not accept credit cards.

You must include the following with the application:

✓ A copy of your APN certificate and copy of the letter authorizing you to prescribe from nursing board must be included with the application.

✓ A statement, signed by yourself and a pharmacist who is registered with the board of pharmacy indicating that the pharmacist is available as a consultant concerning the dispensing of controlled substances, poisons, dangerous drugs and devices.

✓ Written verification from the state board of nursing that you have passed an examination on Nevada law relating to pharmacy.

Upon receipt of the completed application, fee and required documents, a license to prescribe/dispense will be issued. You must have prescribing and dispensing privileges with the Nevada nursing board to receive prescribing and dispensing privileges from the Pharmacy Board.

If you are interested in a DEA number to prescribe controlled substances, please contact DEA at 702/759-8202 in Las Vegas to receive an application. You can also go to DEA's website at [www.deadiversion.usdoj.gov](http://www.deadiversion.usdoj.gov) to apply for a DEA number with a credit card. The Nevada State Board of Pharmacy office does not have new application forms.

All registrations expire October 31, of the even numbered years. If you have any questions, please feel free to contact the Reno office at (775) 850-1440.

**NEVADA STATE BOARD OF PHARMACY**

431 W. Plumb Lane ≈ Reno, NV 89509 ≈ (775) 850-1440

**APPLICATION FOR ADVANCED PRACTITIONER OF NURSING • DISPENSE**

**REGISTRATION FEE: \$300.00 (non refundable)**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M or F

E-mail address: \_\_\_\_\_

**PRACTICING LOCATION**

Practice Name (if any): \_\_\_\_\_

Physical Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Board of Nursing APN Certificate #: \_\_\_\_\_ Issued: \_\_\_\_\_ Expires: \_\_\_\_\_

**SUPERVISING PHYSICIAN**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

- 1) I have  I have not  been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse.
- 2) I have  I have not  been charged, arrested or convicted of a felony or misdemeanor.
- 3) I have  I have not  been the subject of an administrative action whether completed or pending.
- 4) I have  I have not  had a license suspended, revoked, surrendered or otherwise disciplined, including any action against my license that was not made public.

If you checked "I have" to questions 2, 3 or 4 above, please include the following information and an explanation and/or documents.

a) Board Administrative Action State: \_\_\_\_\_ Date: \_\_\_\_\_ Case Number: \_\_\_\_\_

and/or

b) Criminal Action State: \_\_\_\_\_ Date: \_\_\_\_\_ Case Number: \_\_\_\_\_

County: \_\_\_\_\_ Court: \_\_\_\_\_

I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

\_\_\_\_\_  
Signature of APN

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

**Board Use Only**  
Received \_\_\_\_\_ Check Number \_\_\_\_\_ Amount \_\_\_\_\_