

Physician's Assistant (PA) - 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 the registration certificate issued by the board of medical examiners or the state board of osteopathic medicine.

✓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.

You will be required to take and pass a law exam for dispensing physician's assistants relating to pharmacy law before licensure with the board of pharmacy.

You will be sent a copy of Nevada Laws when we receive your completed application. The law exam can be taken at any time after receipt of the law book.

Issuance of a dispensing physician's assistant certificate of registration will **NOT** be granted until passage of the law exam and you **must be** registered with the Nevada medical or osteopathic board to receive 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 to apply for a DEA number with a credit card.

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 PHYSICIAN'S ASSISTANT • 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: _____
Medical/Osteopathic Board PA #: _____ Issued: _____ Expires: _____

SUPERVISING PHYSICIAN

Supervising Physician: _____ Degree: _____
Physical Address: _____ Suite #: _____
City: _____ State: _____ Zip Code: _____

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|----|---------------------------|---|
| 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 Physician's Assistant Date

Signature of Supervising Physician Date

Board Use Only
Received _____ Check Number _____ Amount _____