Physicians Assistant (PA) - Prescribe

This application cannot be returned by fax or email.
We must have an original signature(s) and fee to process.

Download application and mail to the address on the top of the application with the required $80.00 fee. The fee is payable by money order or cashier's check only, we do not accept personal or business checks, cash or credit cards. If the application is received with a personal check or cash, it will be returned and will delay the processing of your application.

Fee is made payable to: ***Nevada State Board of Pharmacy***

Before calling with questions, please read all information carefully.

If you do not have a state license number as yet, leave blank. We cannot process the application until you have notified us of your license number. A copy of the registration certificate issued by the board of medical examiners or the state board of osteopathic medicine must be included with the application. Your license must be active to apply for prescribing privileges.

Upon receipt of the completed application, fee and required documents, a license to prescribe can be issued. You **must** be registered with the Nevada medical or osteopathic board to receive prescribing privileges from the Pharmacy Board.

DO NOT APPLY FOR A DEA NUMBER UNTIL YOU RECEIVE AN EMAIL FROM THE BOARD. We will also provide information on registering for the PMP.

All registrations expire **October 31, of the even numbered years**, no matter when the license is issued. If you have any questions, please feel free to contact the Reno office at 775/850-1440.

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy #206 – Reno, NV 89521

APPLICATION FOR PHYSICIAN'S ASSISTANT - PRESCRIBE

REGISTRATION FEE: $80.00 (non-refundable money order or cashier's check only)

First: _____ Middle: _____ Last: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

SS#: _____ Date of Birth: _____ Sex: ☐ M or ☐ F

Telephone: _____ E-mail address: _____

PRACTICING LOCATION

Practice Name (if any): _____

Physical Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Medical/Osteopathic Board PA #: _____ Issued: _____ Expires: _____

☐ **Check this box if you are a PA who intends to apply for DEA Registration. Board Staff will notify DEA and you of the required information and provide a letter with your pending number to allow you to apply for the DEA in Nevada-(Do not apply to DEA before receiving your pending letter.)**

You must have a current Nevada license with your respective BOARD before we will process this application. The Nevada license must remain current to keep the controlled substance registration.

	Yes	No
1. Have you been diagnosed or treated for any mental illness, including alcohol or substance abuse, or a physical condition that would impair your ability to perform the essential functions of your license?	☐	☐
2. Have you been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☐
3. Have you been the subject of a board citation, administrative action whether completed or pending in any state?	☐	☐
4. Have you had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☐

If you marked **YES** to any of the numbered questions (**1-4**) above, include the following information & **provide an explanation & documentation**:

Board Administrative Action:	State	Date:	Case #:
		/ /	

Criminal Action:	State	Date:	Case #:	County	Court
		/ /			

It is a violation of Nevada law to falsify this application and sanctions will be imposed for misrepresentation. I hereby certify that I have read this application. I certify that all statements made are true and correct.

I understand that Nevada law requires a licensed APRN who, in their professional or occupational capacity, comes to know or has reasonable cause to believe, a child has been abused/neglected, to report the abuse/neglect to an agency which provides child welfare services or to a local law enforcement agency.

Signature of PA, no copies or stamps accepted _____ Date / /

Required Signature of Supervising Physician _____ Required Supervising Physician – Please Print _____ Date

Board Use Only: Date Processed _____ Amount _____