

Advanced Practice Registered Nurse (APRN) - 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 that you have prescribing privileges with the Nevada State Board of Nursing. You **must have current** prescribing privileges with the Nevada nursing board to receive prescribing privileges from the Pharmacy Board. You must have a **Nevada** practicing address to apply for prescribing privileges with 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. The Nevada State Board of Pharmacy office does not have new application forms.

The attached addendum is required if you will be applying for a DEA number. Please include with the Nevada application. If you currently have a DEA number and wish to transfer it to Nevada, please complete the attached DEA transfer form and return with the application with a copy of your DEA certificate.

Upon receipt of the completed application, fee and required documents, a license to prescribe can be issued and mailed to your Nevada work location.

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

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE • PRESCRIBE

REGISTRATION FEE: \$80.00 (non-refundable money order only, no cash)

First: _____ Middle: _____ Last: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

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

Telephone: _____ E-mail address: _____

Board of Nursing APRN Certificate #: _____ Issued: _____ Expires: _____

PRACTICING LOCATION (Required)

Practice Name (if any): _____

Physical Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

		Yes	No
<p>Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or Physical condition that would impair your ability to perform the essential functions of your license?.....<input type="checkbox"/> <input type="checkbox"/></p>			
1. Been charged, arrested or convicted of a felony or misdemeanor in <u>any</u> state?.....		<input type="checkbox"/>	<input type="checkbox"/>
2. Been the subject of a board citation, administrative action whether completed or pending in <u>any</u> state?.....		<input type="checkbox"/>	<input type="checkbox"/>
3. Had your license subjected to any discipline for violation of pharmacy or drug laws in <u>any</u> state?.....		<input type="checkbox"/>	<input type="checkbox"/>
<p>If you marked YES to any of the numbered questions (1-3) above, include the following information & provide an explanation & documentation:</p>			
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.

By checking this box, no collaborating physician is required per my Nursing Board license.

Original Signature of APRN, no copies or stamps accepted _____ Date _____

COLLABORATING PHYSICIAN's name (If required): _____

Original Signature of Supervising Physician, no copies or stamps accepted _____ Date _____

Board Use Only: Date Processed _____	Amount _____
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Nevada State Board of Pharmacy
431 W Plumb Lane
Reno, NV 89509
(775) 850-1440

Required Addendum for APRN's applying for DEA registrations

Please complete the following information and return with the application. When the completed form has been received and is complete, we will notify DEA 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 a pending letter.

Name: _____ . APRN

Practicing Address: _____
(This cannot be a home address)

City: _____ State: NV Zip: _____

Work Telephone: _____

Work Fax: _____

Supervising Physician Name, if required: _____
(Please print)

APRN Signature: _____ Date: _____

***** When you receive your DEA certificate, fax (775/850-1444) a copy to the Reno office and the Nevada State Board of Nursing. DEA will not provide the board of pharmacy with a copy. Upon receipt of the DEA certificate copy and confirmation form the Nursing Board of Nursing, a Nevada certificate of registration will be issued**

Board Use Only

Date Processed and DEA Notified: _____

Pending CS #: _____



**UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION**

LAS VEGAS DIVISION
550 S. MAIN STREET
ATTN: REGISTRATION
LAS VEGAS, NV 89101
(702) 759-8000

DEAR REGISTRANT:

IN ORDER TO TRANSFER YOUR FEDERAL DEA NUMBER IT WILL BE NECESSARY FOR YOU TO COMPLETE THIS FORM. PLEASE COMPLETE ALL ITEMS. **BE SURE TO USE A BUSINESS ADDRESS AS YOUR REGISTERED ADDRESS. DO NOT USE A HOME ADDRESS OR A P.O. BOX.**

DEA NUMBER _____ DATE OF RELOCATION _____

PRINT NAME _____ DAYTIME PHONE # (____) _____

EMAIL _____ FAX PHONE # (____) _____

NEW BUSINESS ADDRESS (Do not use home address or PO Box)

NEW MAILING ADDRESS

NEW STATE LICENSE NUMBERS

Medical License # _____ Expiration Date _____

CS License # _____ Expiration Date _____

DO YOU NEED DEA-222 ORDER FORMS YES _____ NO _____

REGISTRANT SIGNATURE

DATE

FAX TO (702) 759-8245

FOR ADDITIONAL INFORMATION CALL: (702) 759-8202 PST