Physician 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 business check, personal check or cash, it 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, leave blank. We cannot process the application until you have notified us of your license number. 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.

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 for all schedules. Include with the 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.

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 PHYSICIAN ASSISTANT (PA) • PRESCRIBE

REGISTRATION FEE: $80.00 (non-refundable **cashier's check or 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: _____

PRACTICING LOCATION (Required)

Practice Name (if any): _____

Physical Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

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

SUPERVISING PHYSICIAN – Please Print

Supervising Physician: _____ Degree: _____
(Please print)

Physical Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

	Yes	No
1. **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?**	☐	☐
2. Been charged, arrested or convicted of a felony or misdemeanor in <u>any</u> state?	☐	☐
3. Been the subject of a board citation or an administrative action whether completed or pending in <u>any</u> state?	☐	☐
4. Had your license subjected to any discipline for violation of pharmacy or drug laws in <u>any</u> state?	☐	☐

If you marked **YES** to any of the numbered questions (**2,3,4**) above, include the following information & **provide an explanation & documentation**:

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

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

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 PA 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.

_____ _____

Original Signature of PA (No copies or stamps accepted) Date

_____ _____

Original Signature of Supervising Physician (No copies or stamps accepted) Date

Board Use Only: Date Processed: _____ Amount_____

Nevada State Board of Pharmacy
431 W Plumb Lane
Reno, NV 89509
(775) 850-1440

Required Addendum for PA's applying for DEA registrations
This is required to apply for all schedules.

Please complete the following information and fax to (775) 850-1444 if you already have an application or license on file. 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.

PLEASE PRINT

Name:_____. PA

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

City: _____ State: NV Zip: _____

Work Telephone: _____

Work Fax: _____

Email Address: _____

PA Signature: _____ Date: _____

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

Board Use Only

Date 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