NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Parkway, Suite 206 - Reno, NV 89521 - (775) 850-1440

APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE TO PRESCRIBE

Rev (05/19/2021)

This application cannot be returned by fax or email.
An original signature and fee are required to process.

Approval of this application is required for an Advanced Practice Registered Nurse (APRN) to receive authority to prescribe dangerous drugs and/or controlled substances. A registration to prescribe is a revocable privilege, and no holder of such a license acquires any vested right therein or thereunder.

Print and mail the completed application to the address indicated above with a **non-refundable fee** of:

- **$80.00 if applying to prescribe Dangerous Drugs ONLY**
- **$200.00 if applying to prescribe Dangerous Drugs AND Controlled Substances (CS).** When the Nevada State Board of Pharmacy receives your completed application, you will receive an email with DEA and Prescription Monitoring Program (PMP) registration instructions, and a **PENDING CS** registration number so that you may apply for your DEA registration. **DO NOT apply for a DEA registration before receiving your PENDING CS registration number.**

Fees can be paid for by credit card, debit card, personal check, cashier's check, or money order made payable to the **Nevada State Board of Pharmacy**. Credit and debit card payments are charged a **5% processing fee**.

Please Note:

- You **MUST have a current license and active-PRESCRIBING status** with the Nevada State Board of Nursing to apply for and maintain a prescribe or a controlled substance registration.
- You **MUST** provide a copy of your DEA certificate and you **MUST** register with the PMP to obtain your controlled substance registration. You **ARE NOT** authorized to prescribe controlled substances until you have your controlled substance registration.
- If a change in the location of practice or the collaborating physician of an APRN occurs, the APRN shall submit the change in writing to the Board. NAC 639.846.
- All registrations expire **October 31, of the even numbered years,** no matter when the license is issued.

If you have any questions, please contact the Nevada State Board of Pharmacy at 775-850-1440.

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What types of drug(s) will you be prescribing?

☐ Dangerous Drugs ONLY **(Non-Refundable $80 Fee)**

☐ Dangerous Drugs AND Controlled Substances (CS) II, III, IV and/or IV **(Non-Refundable $200 Fee). When the Nevada State Board of Pharmacy receives your completed application, you will receive an email with DEA and PMP registration instructions, and a PENDING CS registration number so that you may apply for your DEA registration. DO NOT apply for a DEA registration before receiving your PENDING CS registration number.**

Section 1: Personal Information (NAC 639.850)

First: _____ Middle: _____ Last:_____

Date of Birth: _____ SSN or ITIN:_____ Sex: ☐ M ☐ F ☐ X

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

APRN License #:_____ Specialty: _____

(You **must have a current license and active-PRESCRIBING status** with the Nevada State Board of Nursing to apply for and maintain a prescribe or a controlled substance registration.)

Section 2: Practice Information (A practice address is required for processing of your application.)

Practice Name:_____

Practice Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Section 3: NRS 632.237 (Complete this section if you are applying to also prescribe SCHEDULED II CS).

An advanced practice registered nurse may apply to prescribe CS listed in schedule II if they meet one of the following qualifications (please mark that apply):

☐ I have at least 2 years or 2,000 hours of clinical experience; OR

☐ The CS will be prescribed pursuant to a protocol approved by a collaborating physician. (If you marked this answer, provide the information as requested below per NAC 639.850.)

Collaborating Physician Name: _____

Collaborating Physician Practice Address:_____ Suite #: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Section 4: Federally Mandated Requirement (NRS 425.520, NRS 639.129)	Yes	No
1. Are you the subject of a court order for the support of a child? (If "yes", answer question 2.)		
2. Are you in compliance with the order or the plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order?		

Section 5: Military Service (NRS 622.120)	Yes	No
1. Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		
2. Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		
3. Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		

Section 6: Personal and Professional History	Yes	No
1. Have you 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. 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 or an administrative action whether completed or pending in any state?		
4. Has your license been subjected to any discipline for violation of pharmacy or drug laws in any state?		

If you marked YES to any questions above, include the following information and provide a signed statement of explanation. Copies of any documents that identify the circumstance or contain an order, agreement or other disposition is required.

Board Administrative Action:	State:	Date:	Case #:

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

I certify under penalty of perjury that the information contained in this application is accurate, true and complete in all material respects. I understand that making any false representation in this application is a crime under NRS 639.281. I understand that, pursuant to NRS 239.010, this entire application and any portion thereof is a public record unless otherwise declared confidential by law, and will be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020. In the event this application is approved I agree to comply with all applicable federal and state statutes and regulations governing this license or registration and understand that any violation may result in discipline.

_____

Applicant Print Name (First, Last)

_____ _____

Original Signature (electronic, copies or stamps not accepted) Date

COLLABORATING PHYSICIAN's name and signature per Section 3 of the application (if applicable):

_____

Collaborating Physician's Print Name (First, Last)

_____ _____

Original Signature (electronic, copies or stamps not accepted) Date

Board Use Only: Date Processed: _____ Amount: _____

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985 Damonte Ranch Pkwy Suite 206, Reno, Nevada 89521

(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444

• Web Page: bop.nv.gov

Applicant Name: _____

Payment: Pay application fee by providing your credit or debit card information below, or by submitting a check made payable to **Nevada State Board of Pharmacy**.		
Credit Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express	**Credit Card #:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	
Expiration Date: __ __/__ __ (MM/YY	**CVV** (3 digits on back of card): _____	**Amount**: $_____
Name on Card: _____		
Billing Address: _____ _____ _____		