NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE (APRN)- Prescribe/Controlled Substance Registration Application

Rev (01/05/2023)

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 APRN to receive authority to prescribe dangerous drugs and/or controlled substances. A Prescribe or Controlled Substance (CS) Registration is a revocable privilege, and no holder of such a license acquires any vested right therein or thereunder.

Instructions to apply to prescribe Dangerous Drugs ONLY (PR)

NOTE: A current license and active-PRESCRIBING status with the Nevada State Board of Nursing and a Nevada practice address is required to complete this application and maintain a Prescribe Registration (PR).

A. Mail the completed application to the address indicated above with a **non-refundable fee** of **$80.00.** 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**.

B. If your application is approved, you will receive an email with your **Prescribe Registration (PR)**.

Instructions to apply to prescribe Dangerous Drugs AND Controlled Substances (CS)

NRS 453.232 A person who dispenses, prescribes, or administers a controlled substance without being registered by the Nevada State Board of Pharmacy (Board) is guilty of a CATEGORY D FELONY and shall be punished as provided in NRS 193.130. A practitioner MUST COMPLETE in SEQUENTIAL ORDER and obtain ALL the following for authorization to prescribe controlled substances in Nevada. Failure to complete all the requirements could result in disciplinary action.

Step 1: Obtain your Nevada Prescription Monitoring Program (PMP) account

A. Visit nevada.pmpaware.net, click "Create an Account", and follow the instructions on the webpage to complete your registration. For assistance contact the PMP at 775-687-5694 or pmp@pharmacy.nv.gov.

B. If your PMP registration is approved, you will receive an automated email confirmation from "No Reply PMP Aware". It is a system-generated email so it may go into your spam or junk file. Once you receive this email proceed to **Step 2**.

Step 2: Submit your Controlled Substance (CS) Application

NOTE: A current license and active-PRESCRIBING status with the Nevada State Board of Nursing AND a Nevada practice address is required to complete this application and maintain a CS Registration.

A. Complete and mail the application that is **attached** to these instructions to the address indicated above with the required **non-refundable fee** of **$200.00**. 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**.

B. If your application is approved, you will receive an email with your **CS Registration**. Proceed to **Step 3**.

Step 3: Obtain your Drug Enforcement Administration (DEA) Registration

NOTE: An active CS Registration is required to complete this application.

A. Complete the on-line DEA application at deadiversion.usdoj.gov. If you have a DEA number from another state, and want to transfer that DEA number to Nevada, you will need to complete the DEA Registration Change Requests form.

B. If your application or form is approved by the DEA, you will receive your DEA certificate in the mail.

C. You **MUST** email (pharmacylicensing@pharmacy.nv.gov) or fax (775-850-1444) a copy of your DEA certificate to the Board.

You are NOT AUTHORIZED to prescribe controlled substances unless you have an active PMP account, an active CS registration, AND an active DEA registration (in which a copy of the certificate has been provided to the Board).

Prescribe and CS Registrations expire OCTOBER 31, OF EVEN NUMBERED YEARS, despite when the registration is issued. You MUST notify the Board in writing of any changes to the location of your practice or collaborating physician. NAC 639.846.

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APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE TO PRESCRIBE

Rev (01/05/2023)

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

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

☐ Dangerous Drugs AND Controlled Substances (CS) I, II, III, IV and/or V **(Non-Refundable $200 Fee) (CS)**
Select the Controlled Substance Schedules you are applying to prescribe

☐ Schedule I ☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

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: _____

(A **current license and active-PRESCRIBING status** with the Nevada State Board of Nursing is required to apply for and maintain a Prescribe or a CS 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?		

Please use and make copies of this page (if necessary) to provide information regarding any questions, 1-4, you have marked "YES" to in section 6 of the application. A signed statement of explanation for each event and a copy of all documents that identify the circumstance or contain an order, agreement or other disposition for the event must be provided.

This is in response to Question # _____. Provide all the following *where applicable*:

Date of Event/Arrest	Disposition Date	State	City	County

Case #	Governing, licensing, Arresting Presiding Body/Agency/Court

Reason/Charge

Plaintiff/Defendant/Claimant/Respondent	Lawsuit/Arbitration/Bankruptcy

Name of Business/Industry/Entity

Provide explanation below:

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

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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(775) 850-1440 • (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: _____ _____ _____		