NEVADA STATE BOARD OF PHARMACY

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

Physician Assistant (PA) - Dispensing Registration Application

Non-Refundable $300 fee

Rev (06/16/2022)

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

Approval of this application is required to request for a PA Dispensing Registration. A PA Dispensing Registration is required for a PA to ***dispense***[1] drugs from an office or facility. A PA Dispensing Registration is a revocable privilege, and no holder of such a license acquires any vested right therein or thereunder. NRS 639.1373, NAC 639.272, NAC 639.285, NAC 639.742, NAC 639.745.

Pre-requisite for a PA Dispensing Registration:

1. Before a PA Dispensing Registration may be issued, the PA MUST have a current and active registration to ***prescribe*** dangerous drugs (DD) issued by the Nevada State Board of Pharmacy (Board). If dangerous drugs and controlled substances (CS) will be dispensed from the office or facility then a ***controlled substance*** registration will be required. If you do not have an active ***prescribe*** or ***controlled substance*** registration, visit www.bop.nv.gov and complete the necessary application. A CS Registration and a DEA license is required for each office or facility where CS dispensing will occur.

Requirements for a PA Dispensing Registration:

1. Print and mail the completed application to the address indicated above with a **non-refundable fee** of **$300.00** paid for by credit or debit card or check, cashier's check or money order made payable to the Nevada State Board of Pharmacy. Credit and debit card payments are changed a 5% processing fee.
2. Upon receipt of a completed application, you will receive an email with instructions on how to access the exam administered by the Board on the laws relating to the dispensing of drugs. NRS 639.1373, NAC 639.272(4)(b). You have multiple attempts to pass the exam with a score of 70% or higher. In preparation for the exam, please review the laws regarding the dispensing of drugs in Nevada Statues & Regulations (nv.gov).
3. The office or facility where the dispensing will occur MAY be required to be inspected by a Board inspector before a PA Dispensing Registration may be issued. You will receive a letter or email regarding the inspection process.
4. Once we receive your completed application, you pass the exam, the office or facility receives a satisfactory inspection, and all other requirements of the board have been completed, you will receive your PA Dispensing Registration in your email. Please check your spam or junk mail.

Please note:

- A separate registration must be obtained for each office or facility where a PA is dispensing drugs.
- A change of location requires the PA to submit a new application with fee. A satisfactory inspection of the new location will be required before a new PA Dispensing Registration will be issued and before any dispensing can take place at the new location.
- The dispensing registration must be renewed in **October of even numbered years** despite when the original license was issued. Fees ARE NOT prorated.
- The information described in NRS 453.163 for CS prescriptions dispensed from the office or facility must be reported to the Nevada Prescription Monitoring Program (PMP) by the end of next business day after dispensing the CS. NAC 639.926. Registration and information regarding reporting to the PMP can be found at: https://bop.nv.gov/links/PMP/.
- For questions contact us at 775-850-1440 or by email at pharmacy@pharmacy.nv.gov.

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[1] **NRS 639.0065:** "Dispense" means to deliver a controlled substance or dangerous drug to an ultimate user, patient or subject of research by or pursuant to the lawful order of a practitioner, including the prescribing by a practitioner, administering, packaging, labeling or compounding necessary to prepare the substance for that delivery.

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Type of Application

☐ New Dispensing Location
☐ Dispensing Location Ownership Change (Provide current Dispensing Registration #: ________________)
☐ Dispensing Location Address Change (Provide current Dispensing Registration #: ________________)

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

☐ Dangerous Drugs (DD) ONLY (Provide your Prescribe Registration #: ________________)
☐ Dangerous Drugs (DD) AND Controlled Substances (CS) (Provide your Controlled Substance Registration #: ________________)

Is the office or facility from which the practitioner intends to dispense DD/CS wholly owned and operated by the practitioner?

☐ Yes
☐ No (Facility owner(s) must complete the Personal History application at www.bop.nv.gov. Submit this with your application.)

Section 1: Personal Information

First: ______________________________ Middle: _________________________ Last: ______________________________

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

Home Address: ____

City: ____ State: ___________ Zip: ____________________________

Telephone: _________________________ Email: ____

Degree:___________________ Practitioner License #: __________________ Specialty: ______________________________

(You MUST have a current and active license with your respective BOARD to apply for and maintain a PA dispensing registration.)

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

Practice Name: ____

Practice Address: ____ Suite #: _____________________

City: ____ State: ____________ Zip: ________________________

Telephone: __________________ Fax: _____________________ Email: ____

Supervising Physician Name: ____

Section 3: 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 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: 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 5 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.

I understand that Nevada law requires a registered dispensing PA who, in their professional or occupational capacity, knows 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, and make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the child has been abused/neglected. NRS 432B.220.

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Applicant Print Name (First, Last)

__________________________________ ______________________

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

Required Supervising Physician's name and signature (NAC 639.272):

____

Supervising 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 cards are charged a 5% processing fee.		
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: ____ ____ ____		