NEVADA STATE BOARD OF PHARMACY

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

Advanced Practice Registered Nurse (APRN) 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 an APRN Dispensing Registration. An APRN Dispensing Registration is required for an APRN to ***dispense***[1] drugs from an office or facility. An APRN Dispensing Registration is a revocable privilege, and no holder of such a license acquires any vested right therein or thereunder. NRS 639.1375, NAC 639.742, NAC 639.745, NAC 639.870, NAC 639.879, NAC 639.892, NAC 639.898.

Pre-requisite for a APRN Dispensing Registration:

1. You MUST have a current license and active-PRESCRIBING status with the Nevada State Board of Nursing.
2. You MUST have a current license and active-DISPENSING status with the Nevada State Board of Nursing.
3. You 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 an APRN 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 must pass an exam administered by the Nevada State Board of Nursing (BON) on the laws relating to pharmacy. NRS 639.1375. The BON will notify us when you have taken and passed the exam. You may access Nevada law relating to pharmacy at 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 an APRN Dispensing Registration may be issued. You will receive an email regarding the inspection process.
4. Once we receive your completed application, you pass the exam administered by the Nevada State Board of Nursing, the office or facility receives a satisfactory inspection, and all other requirements of the Board have been completed, you will receive your APRN 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 an APRN is dispensing drugs.
- A change in location or ownership of the office or facility requires the APRN to submit a new application with fee. A satisfactory inspection of the new location will be required before a new APRN Dispensing Registration will be issued and before any dispensing of CS and DD 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 paragraph (d) of subsection 1 of NRS 453.162 for CS prescriptions dispensed from the office or facility must be reported to the Nevada Prescription Monitoring Program by no later than the end of the next business day after dispensing the CS. NAC 639.926. Registration information can be found at: PMP (nv.gov)
- 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 APRN Dispensing 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 (ONLY complete this section if you are applying to also *dispense* SCHEDULED II CS. In order to dispense SCHEDULED II CS, you must meet the requirements to *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 639.870(4))

Collaborating Physician Name: _____

Collaborating Physician Practice Address: _____

City: _____ State: _____ Zip:_____

Telephone: _____ Fax: _____ Email:_____

Section 4: 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 5: 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 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.

I understand that Nevada law requires a registered dispensing APRN 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.

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:

NEVADA STATE BOARD OF PHARMACY

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: _____ _____ _____		