

## NEVADA STATE BOARD OF PHARMACY

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

### **CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)- Controlled Substance Registration Application**

**Non-Refundable \$200 fee**

Rev (12/28/2023)

[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 CRNA, **under the supervision of a physician** licensed pursuant to chapter 630 or 633 of NRS, to receive authority to order, prescribe, possess and administer controlled substances, poisons, dangerous drugs and devices to treat a patient **under the care of a licensed physician** in a **critical access hospital** in preparation for surgery or childbirth, during surgery and childbirth, and while a patient recovers from surgery and childbirth. A critical access hospital means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. 1395i-4(e). A 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 order, prescribe, possess, and administer 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 CRNA **MUST COMPLETE** in **SEQUENTIAL ORDER** and obtain **ALL** the following to receive a CS registration in Nevada. Failure to complete all the requirements prior to the ordering or prescribing of controlled substances, poisons, dangerous drugs and devices could result in disciplinary action.

#### **Step 1: Obtain your Nevada Prescription Monitoring Program (PMP) account NRS 453.226**

- A. Visit [nevada.pmpaware.net](http://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](mailto: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 and active certificate of registration to practice as a CRNA issued by the Board of Nursing 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](http://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](mailto:pharmacylicensing@pharmacy.nv.gov)) or fax (775-850-1444) a copy of your DEA certificate to the Board.

**You are NOT AUTHORIZED to order, prescribe, possess, and administer controlled substances, poisons, dangerous drugs and devices to treat a patient under the care of a licensed physician in a critical access hospital in preparation for surgery or childbirth, during surgery and childbirth, and while a patient recovers from surgery and childbirth 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).**

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. **NAC 453.130**.

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**Select the controlled substances you will be ordering, prescribing, possessing, and administering in a critical access hospital**

Schedule I       Schedule II       Schedule III       Schedule IV       Schedule V

**Section 1: Personal Information**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN or ITIN: \_\_\_\_\_ Sex:  M     F     X

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

CRNA License #: \_\_\_\_\_

*(A current and active certificate of registration to practice as a CRNA issued by the Board of Nursing is required to complete this application and maintain a CS Registration.)*

**Section 2: Critical Access Hospital**

Name of Hospital: \_\_\_\_\_

Hospital Address: \_\_\_\_\_ Department or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

<b>Section 4: Federally Mandated Requirement (NRS 425.520, NRS 639.129)</b>	<b>Yes</b>	<b>No</b>
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?		

<b>Section 5: Military Service (NRS 622.120)</b>	<b>Yes</b>	<b>No</b>
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

Board Use Only: Date Processed: \_\_\_\_\_ Amount: \_\_\_\_\_



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985 Damonte Ranch Pkwy Suite 206, Reno, Nevada 89521

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

• Web Page: [bop.nv.gov](http://bop.nv.gov)

**Applicant Name:** \_\_\_\_\_

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