

**REQUEST FOR CHANGE IN PHYSICIAN(S) SUPERVISING
ADVANCED PRACTICE PRESCRIPTIVE AUTHORITY
(CNP, CNM, CNS)**

Fee - \$10.00 per "Request for Change" form submitted

Instructions

1. Application:

Complete and submit the *Request for Change in Physician(s) Supervising Advanced Practice Prescriptive Authority* and sign before a Notary Public for any changes (addition or deletion) of physician(s) supervising advanced practice prescriptive authority. The change must be filed with the Board within 30 days of the change and shall be effective upon filing. The form must be typed or completed in blue or black ink. Do not use correction fluid on the forms.

2. Addition of Supervising Physician:

An Agreement for Physician Supervising Advanced Practice Prescriptive Authority (attached) must be completed and signed by each new supervising physician in front of a Notary Public. The form must be completed with no white-out. The agreement must be submitted with the *Request for Change in Physician(s) Supervising Advanced Practice Prescriptive Authority*.

3. Deletion of Supervising Physician:

Clearly indicate the full name of the supervising physician to be deleted on the *Request for Change in Physician(s) Supervising Advanced Practice Prescriptive Authority*.

4. Fee

There is a fee of \$10.00 for each *Request for Change in Physician(s) Supervising Advanced Practice Prescriptive Authority* form submitted. On each form, you may add up to five physicians and/or delete up to five physicians. Please submit the payment in the form of a personal check, certified check or money order. Checks may be made payable to the Oklahoma Board of Nursing. If the fee is not submitted with the request or if the fee is incorrect, the request will be returned without review.

The request will be processed within 14 days of receipt of the completed information into the Board office. After 14 days, you may verify the completion of the corrected changes by using the Board's website: www.ok.gov/nursing. Please click on the link for "License Verification" and enter your name or license number, then click on "APN/RX" to view your current supervising physician/s.

Please note that the Advanced Practice Registered Nurse must hold a separate prescriptive authority recognition for each advanced practice license and for each advanced practice specialty certification.

Oklahoma Board of Nursing
2915 N. Classen Blvd., Suite 524
Oklahoma City, OK 73106
(405) 962-1800
www.ok.gov/nursing

***Request for Change in Physician(s) Supervising
Advanced Practice Prescriptive Authority***

Please type, or use blue or black ink to complete the form. Do not use correction fluid.

Check One: CNP _____ CNM _____ CNS _____

RN License Number: _____

1. Name on license _____
First Middle or Maiden Last

2. Mailing address _____ () _____
Street City State Zip Telephone #

3. Work address _____ () _____
Street City State Zip Telephone #

4. Advanced practice specialty certification _____

5. National Certifying Body _____
Name of Certifying Body Date of Expiration of National Certification

6. Practice Setting (Hospital, Nursing Home, etc.) _____

7. Please **add** the following supervising physician(s):

Name MD/DO Circle One Effective Date

Name MD/DO Circle One Effective Date

Name MD/DO Circle One Effective Date

Name MD/DO Circle One Effective Date

Name MD/DO Circle One Effective Date

NOTE: ***An Agreement for Physician Supervising Advanced Practice Prescriptive Authority must be submitted for each new supervising physician.***

AFFIDAVIT

Supervision of Advanced Practice Registered Nurses with prescriptive authority means overseeing and accepting responsibility for the ordering and transmission of written, telephonic, electronic or oral prescriptions for drugs and other medical supplies, subject to a defined formulary [O.S. 567.3a(11) and (12)].

I, _____ agree to supervise the prescriptive authority practice of
Name of supervising physician

_____ effective _____. I further agree to be available for
Name of Advanced Practice Registered Nurse Date

consultation, collaboration, assistance with medical emergencies, and patient referral through direct contact, telecommunications or other appropriate electronic means. I am not in training as an intern, resident or fellow. I have reviewed the *Exclusionary Formulary* approved by the Oklahoma Board of Nursing. I agree to remain in compliance with the Rules and Regulations promulgated by the Oklahoma State Board of Medical Licensure and Supervision (for MDs) or Oklahoma State Board of Osteopathic Examiners (for DOs). Further, I certify that the statements contained in this Agreement are true and correct.

Signature of Physician _____ MD / DO
(Circle One)

Subscribed to and sworn before me, this _____ day of _____, 2_____.

Commission Expires

(SEAL)

Notary Public