

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

Fee - \$10.00 per 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.
- 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 form submitted. 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 nurse must hold a separate prescriptive authority recognition for each advanced practice recognition, which is specific to the specialty area.

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***

Check One: ARNP _____ CNM _____ CNS _____

RN License Number: _____

1. Full name _____
First Middle Maiden Married

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

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

4. Specialty area _____

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

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

8. Please **delete** 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

NOTE: You must have at least one current supervising physician on file; otherwise, your prescriptive authority will be placed on inactive status.

**PRESCRIPTIVE AUTHORITY AFFIDAVIT
(to be completed by the Advanced Practice Nurse)**

I certify that I am the licensee listed above and that the statements listen herein are true.

I agree to contact my physician supervising prescriptive authority, for collaboration and referral as appropriate in relationship to prescriptive practices. I also agree to provide written verification to the Oklahoma Board of Nursing of receipt of my Oklahoma Bureau of Narcotics and Dangerous Drugs Control (*OBND*) Registration and Drug Enforcement Administration (*DEA*) Registration if I will be prescribing Schedule III-V drugs.

I further agree to notify the Board office of any changes in physicians supervising prescriptive authority in writing within 30 days of the change, which shall be effective upon filing.

Signature of Licensee: _____
(Do not print or use initials)

Date: _____

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

My Commission Expires

Notary Public

(SEAL)

AFFIDAVIT

Supervision of advanced practice 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 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