Illinois
New Mexico
Oklahoma
Texas

Advanced Practice Nurse
Prescribing Authority Supplemental Questionnaire

Advance Practice Nurses who plan to prescribe controlled substances and who have been granted prescriptive authority by their state licensing board must comply with DEA and state laws relating to prescribing of controlled substances.

As per the Federal Controlled Substance Act a prescription for a controlled substance may only be issued by a physician, dentist, podiatrist, mid-level practitioner, or other registered practitioners who are:

- Authorized to prescribe controlled substances by the jurisdiction in which the practitioner is licensed to practice; **and**
- Registered with DEA or exempted from registration ; **or**
- An agent or employee of a hospital or other institution acting in the normal course of business or employment under the registration of the hospital or other institution which is registered in lieu of the individual practitioner..

1. Have you (applicant) been approved by your State Licensure Board (if required) to carry out or sign prescription drug orders and been issued a prescription authorization number? ___ **YES** ___ **NO**

2. Do you plan to prescribe controlled substances? **Illinois and New Mexico**: Schedules II-V **Oklahoma and Texas**: Schedules III-V **Oklahoma CRNA's:** Schedule II-V ___ **YES** ___ **NO**

If No, STOP HERE, attest to this document by signing/dating and returning.

3. **If Yes**, do you possess a **State Controlled Substance Certificate** (CDR/CSR/BNDD DPS)? *Submit a copy of your certificate.* ___ **YES** ___ **NO**
If No, please explain why: _____
_____

4. **If Yes**, do you possess a **Federal Controlled Substance Certificate (DEA)**? ___ **YES** ___ **NO**
Submit a copy of your certificate.
If No, do you practice in one of the following capacities? If so, you are automatically exempt from this requirement and no other explanation will be required.

___ Indian Health Service
___ Public Health Service
___ Federal Bureau of Prisons
___ Military Practitioners
___ Organizational DEA (practitioners who are employed by an educational institution or research institution)
___ Other: If you are exempt by regulation for any other reason, please provide a statement of the reason for the exception: _____
_____

If No to questions 3 or 4. Please provide the name of the practitioner(s) who will prescribe for patients who need prescriptions for medications requiring a DEA or State Controlled Substance certificate:

Practitioner Name: _____ **Medical License No:** _____ **State:** __

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Pending DEA or State Controlled Substance Certificates: If the applicant/provider has a pending DEA application, the provider must have an agreement with a participating network provider with a valid DEA and State Controlled Substance Certificate (in each state where the applicant/provider intends to practice) to write prescriptions for the applicant/provider until the DEA application has been completed. Please submit a copy of the agreement or letter stating the name of the provider who will be writing prescriptions for the applicant/provider. If your DEA or DPS/CDS-CSR certificates are pending, please list the name and Medical License Number of a practitioner who will prescribe for you:

Practitioner Name: _____ **Medical License No:** _____ **State:** ___

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ATTESTATION: I certify the information provided by me on this document is true, correct and compete to the best of my knowledge and belief. I understand and agree that any misstatement or omission of information concerning administering, dispensing or the prescribing of controlled substances may constitute grounds for withdrawal of the application for consideration.

_____

Signature: Applicant **Date**

_____

Printed Name

Posted 02/2013