PENNSYLVANIA STATE BOARD OF NURSING
P.O. BOX 2649
HARRISBURG, PA 17105-2649

PHONE (717) 783-7142
FAX (717) 783-0822
www.dos.state.pa.us/nurse
Email: st-nurse@pa.gov

Instructions for Certified Registered Nurse Practitioner (CRNP) Prescriptive Authority Application

To prescribe and dispense drugs in Pennsylvania you must have an active Pennsylvania RN license, an active Pennsylvania CRNP Certificate and active Prescriptive Authority Approval.

FAQs AND LAW/REGULATIONS

- FAQs on Prescriptive Authority can be found on the Board's website by clicking on "Board Forms/Applications."
- The Law and Regulations can be found on the Board's website by clicking on "RN Law" and "Rules and Regulations".

GENERAL INSTRUCTIONS

- Mail the completed application and fee to the Board at the above address, ATTN: CRNP Area.
- All questions must be answered completely and all fees submitted in order for the application to be processed.
- To verify that a license/certificate or Prescriptive Authority Approval was issued visit **www.licensepa.state.pa.us**.
- Social Security Numbers must be provided*. If a waiver is submitted it cannot be used to renew a prescriptive authority approval.
- Applications must be received in the Board office within 90 days from the date the affidavit is signed.
- Applications are **valid for one year** from the date the affidavit is signed.
- When licenses/certificates are not issued within the one year, new applications, including fees, must be submitted.

FEES

- Fees must be paid by personal check, cashier's check or money order and must be made payable to the "**Commonwealth of Pennsylvania".**
- **Fees are not refundable**.
- Cash and credit cards are not accepted.
- Check/money orders drawn on foreign banks are only acceptable when "US funds" is identified on the check/money order.
- A $20.00 processing fee will be charged for a check/money order returned unpaid. Applications will not be processed until the corrected fee is received.

NAME / ADDRESS

- Applicant's name must be entered on the application as it currently appears on the RN license and CRNP Certificate.
- Licenses/certificates are not forwarded.
- Complete and submit the "Form to Request Change Name &/or Address …" located on the Board's website, whenever there is a change of name &**/or** address. Licensees are responsible to advise the Board of any address or name change within 10 days of the change.

CRIMINAL / DISCIPLINARY HISTORY (Form 1, Section B)

If "YES" was checked for any question in Section B, submit:

- A detailed, signed and dated personal explanation of the circumstances surrounding the action and its outcome.
- A Criminal History Records Check **(CHRC)** from a State Law Enforcement Authority in all states where you lived in the last five years dated within 6 months of the date the application is submitted.
- Certified copies of Court documents (Applicable ONLY to #1)
- Certified copies of all disciplinary actions from the Boards that imposed action (Applicable ONLY to #2 and #3).
- Certified copies of the DEA denials, revocations or restrictions (Applicable ONLY to #4)

CONTINUING EDUCATION ON RENEWAL

CRNPs with Prescriptive Authority must verify completion of at least 16 CE hours of pharmacology out of the total 30 hours of Board-approved continuing education obtained in the 2-year period immediately preceding renewal. Refer to www.dos.state.pa.us/nurse for detailed information about this continuing education renewal requirement.

*Note that disclosing your Social Security Number on this application is mandatory in order for this Board to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. §4304.1(a). In order to enforce domestic support orders, the Commonwealth's licensing boards must provide the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Social Security Numbers are also required in order for the Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank.

Applicants for INITIAL CRNP Prescriptive Authority in Pennsylvania must submit

- ☐ *Form 1: Application for CRNP Prescriptive Authority* signed by the applicant.
- ☐ *Form 2: Collaborative Agreement for CRNP Prescriptive Authority* signed by the applicant and collaborating physician. Submit a copy. Keep original at the primary practice location.
- ☐ *Form 3: Verification of Advanced Pharmacology Form (*completed and mailed to the Board by the program director where the Advanced Pharmacology course was taken)
- ☐ A **$50** fee

Applicants for ADDITIONAL CRNP Prescriptive Authority in Pennsylvania must submit*

- ☐ *Form 1: Application for CRNP Prescriptive Authority* signed by the applicant.
- ☐ *Form 2: Collaborative Agreement for CRNP Prescriptive Authority* signed by the applicant and collaborating physician. Submit a copy. Keep original at the primary practice location.
- ☐ A **$30** fee for each additional *CRNP Application for Prescriptive Authority Application*
  ***Note**: An applicant for an ADDITIONAL Prescriptive Authority is applying for a NEW agreement with a NEW collaborating physician. A CRNP may hold multiple prescriptive authority approvals at the same time, each with a different collaborating physician.

FORM 1: APPLICATION FOR CRNP PRESCRIPTIVE AUTHORITY

- Verify all names and license numbers at **www.licensepa.state.pa.us**.
- Pennsylvania CRNP Certificate Number **must** be provided (this begins with **SP-, VP-, TP-, or UP-).** An application with "Pending" status listed cannot be processed until correct and complete.
- The National Certification Number is not required on this application.
- Signature of applicant must be original; fax, email, scan copies will not be accepted. Must provide date.

FORM 2: COLLABORATIVE AGREEMENT FOR CRNP PRESCRIPTIVE AUTHORITY

- The CRNP specialty must be written **exactly as listed** on the Pennsylvania CRNP Certificate. If specialty is not listed, check "other" and print name that is on the CRNP certificate. Verify specialty at www.licensepa.state.pa.us.
- Professional liability insurance
- Answer YES or NO to the question. **Note:** Answer "NO" if you are not practicing or holding yourself out to be practicing as a CRNP *in the Commonwealth*.
  - **Do not attach the insurance policy to the application**.
- Collaborative/Substitute Physician
  - Must hold an active license in Pennsylvania
  - All prefixes/suffixes and zeros are part of a license # and **must** be included in all license numbers.
  - **At least one substitute physician must be listed** in order for the application to be processed,
  - If the agreement includes multiple substitute physicians, check "List of additional substitutes is attached" and attach the list of physician names and license numbers**.** The CRNP and collaborating physician **must** be listed at the top of the attachment.
- Controlled Substance Prescribing Authority
  - Check YES or NO for each Schedule.
  - List the day supply amount for each Schedule requested.
  - The maximum day supply amounts currently permitted by regulation are:
    Schedule II = 30 day supply Schedule III = 90 day supply Schedule IV = 90 day supply
- Maintain a copy of the *Collaborative Agreement for CRNP Prescriptive Authority* submitted to the Board at the primary practice location to be made available for inspection to anyone who requests it. Maintain a personal copy.
- Prescriptive authority is not effective until the approval is issued by the Board.

FORM 3: VERIFICATION OF ADVANCED PHARMACOLOGY FORM

- The applicant must have successfully completed a minimum of 45 hours of course work specific to advanced pharmacology within 5 years of the date the applicant applies for initial prescriptive authority approval. If the course was completed beyond 5 years of the date the applicant applied for initial prescriptive authority, the applicant must submit evidence of prescriptive authority issued in another jurisdiction or continuous professional learning beyond the 5 years.
- Forward Form 3 to the program director where the Advanced Pharmacology course was taken to verify the number of hours of advanced pharmacology content and specialty completed.
- The program director must mail the completed form directly to the Board. FORM 3 will not be accepted by email, scan or fax.

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FORM 1: APPLICATION FOR CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) PRESCRIPTIVE AUTHORITY

ALL FEES ARE NONREFUNDABLE

Applying For: (Check only one.)

☐ ***Initial* Application for** CRNP **Prescriptive Authority in PA ($50.00)**

☐ ***Additional* Application for** CRNP **Prescriptive Authority in PA ($30.00)**

SECTION A: APPLICANT INFORMATION: (Print clearly in dark blue or black ink or type.)

Name: _____
Last First Middle

Date of Birth: _____ U.S. Social Security Number: _____
Month Day Year

Address: _____
Street

_____
City State Zip

(_____)_____ Email Address: _____
Daytime Phone #

Pennsylvania CRNP Certificate Number_____

SECTION B: CRIMINAL / DISCIPLINARY HISTORY: (Answer all the following questions.)

		YES**	NO
1.	Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		

		YES**	NO
2.	Have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		

		YES**	NO
3.	Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		

		YES**	NO
4.	Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?		

***If you answered YES to any of the questions in Section B, see Instructions for additional requirements.**

Name: _____ **SSN:** _____

SECTION C: PRIMARY PRACTICE LOCATION of the CRNP:

Name of Practice _____ Daytime phone number _____
(Must be within the State of Pennsylvania)

Physical Street Address _____

City _____ State _____ Zip Code _____

SECTION D: AFFIDAVIT: READ, SIGN AND DATE. ALL APPLICANTS MUST COMPLETE THIS SECTION.

I verify that the statements in this application for CRNP prescriptive authority are true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsification to authorities, and may result in the suspension, revocation, or denial of my license or certificate. I verify that this form is in the original format as supplied by the Department of State and has not been altered or modified in any way.

_____ _____
Original Signature of Applicant (CRNP) **Date (mm/dd/yyyy)**

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Form 2: COLLABORATIVE AGREEMENT FOR CRNP PRESCRIPTIVE AUTHORITY

1) **Name of Certified Registered Nurse Practitioner:**_____

Pennsylvania CRNP Certificate Number: _____

CRNP Specialty for this Collaborative Agreement for Prescriptive Authority: _____

Do you either maintain or are you exempt from having the required professional liability insurance? ☐ **YES** ☐ **NO**

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2) **Collaborating Physician:** Name: _____

Pennsylvania License Number: _____
(Include prefix/suffix)

Substitute Physician: Name: _____
(At least one (1) substitute physician is required.)

☐ List of additional substitutes is attached

Pennsylvania License Number:_____
(Include prefix/suffix)

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3) **Indicate the circumstances and how often the collaborating physician will personally see the patient. (Must check at least one.)**

☐ Once per year	☐ Every other visit	☐ Patient not responding to treatment
☐ Twice per year	☐ CRNP Request	☐ Patient condition outside CRNP scope of practice
☐ Daily	☐ Patient or Family request	☐ Other _____

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4) **Controlled Substance Prescribing Authority: (Check YES or NO for each Schedule.)**

Schedule II

☐ Yes, I am requesting **Schedule II** for up to a _____ day supply
☐ No

Schedule III

☐ Yes, I am requesting **Schedule III** for up to a _____ day supply
☐ No

Schedule IV

☐ Yes, I am requesting **Schedule IV** for up to a _____ day supply
☐ No

COLLABORATIVE AGREEMENT FOR PRESCRIPTIVE AUTHORITY (continued)

Name of Certified Registered Nurse Practitioner: _____

Pennsylvania CRNP Certificate Number: _____

5) Drug Categories: Individually check (☑) each category of drugs from which the CRNP may prescribe and dispense. The box must be **blank** if you are not selecting the category. **Do not alter any category box.**

	(a) Antihistamines
	(b) Anti-infective agents
	(c) Antineoplastic agents
	(d) Unclassified therapeutic agents
	(e) Devices and pharmaceutical aids
	(f) Autonomic drugs
	(g) Blood formation drugs
	(h) Coagulation and anticoagulation drugs
	(i) Thrombolytic and antithrombolytic agents
	(j) Cardiovascular drugs
	(k) Central nervous system agents
	(l) Contraceptives including foams and devices
	(m) Diagnostic agents
	(n) Disinfectants for agents used on objects other than skin
	(o) Electrolytic, caloric and water balance
	(p) Enzymes
	(q) Antitussive, expectorants and mucolytic agents
	(r) Gastrointestinal drugs
	(s) Local anesthetics
	(t) Eye, ear, nose and throat preparations
	(u) Serums, toxoids and vaccines
	(v) Skin and mucous membrane agents
	(w) Smooth muscle relaxants
	(x) Vitamins
	(y) Hormones and synthetic substitutes

6) Indicate the date you are requesting this agreement to become effective: _____
(mm/dd/yyyy)

This Collaborative Agreement for Prescriptive Authority contains the details regarding the prescribing and dispensing of drugs between the following parties:

_____
Signature of CRNP Date Signed (mm/dd/yyyy)

_____
Signature of Collaborating Physician Date Signed (mm/dd/yyyy)

FORM 3: VERIFICATION OF ADVANCED PHARMACOLOGY

The following information must be completed by the director of the educational program or designee, who can verify that the CRNP successfully completed at least 45 hours of course work in advanced pharmacology. *The regulations require~~s~~ that the course work in advanced pharmacology must be at an advanced level, that is, it must be above a pharmacology course required by a professional nursing (RN) education program.* ***NOTE: If one course alone does not total 45 hours but pharmacology content was incorporated into more than one course, please provide all course titles, numbers, and completion dates. The total number of advanced pharmacology hours completed must be listed on the line where indicated.***

Provide the last 4 numbers of the applicant's Social Security Number XXX-XX-_____

I hereby certify that _____ successfully completed _____ hours of
(Applicant's Name) (Total # of Hours)

ADVANCED PHARMACOLOGY at _____
(Full Name of the University or College)

as part of the _____ Nurse Practitioner Program.
(List specialty of the CRNP Program)

Check One:

☐ **This course WAS part of a Pennsylvania Board Approved CRNP Program.**

☐ **This course WAS NOT part of a Pennsylvania Board approved CRNP program. Course description, catalog and/or course syllabus are attached. Additional information about the course(s) may be requested by the Board.**

Course Title(s): _____

Course Number(s): _____

Completion Date(s): _____

I verify that the above statements are true and correct as validated by my review of the applicant's school records. I verify that the information communicated on this form is true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsification to authorities.

SCHOOL SEAL

_____
Original Signature of CRNP Program Director or designee

_____
Type or Print Name of the CRNP Program Director or designee

_____
Date Signed (mm/dd/yyyy)

_____
Name of University or College

_____
Mailing Address

_____
City, State, Zip Code

_____
Phone Number

DO NOT RETURN THIS FORM TO APPLICANT

MAIL DIRECTLY TO THE PENNSYLVANIA STATE BOARD OF NURSING IN AN OFFICIAL SCHOOL ENVELOPE.

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