FOR OFFICE USE ONLY:
Fee Received: ______
Pending # ______
Practice Agreement Approved: ______
Permanent #0017 ______
Date Issued: ______

COMMONWEALTH OF VIRGINIA
Department of Health Professions - Board of Nursing
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804)367-4515 – PHONE (804) 527-4455 – FAX
web: **www.dhp.virginia.gov** email: nursebd@dhp.virginia.gov

APPLICATION FOR PRESCRIPTIVE AUTHORITY FOR LICENSED NURSE PRACTITIONERS

Please provide the information below and on the back of this page.

I hereby make application for approval of prescriptive authority. The following information in support of my application is submitted with a check or money order for **$75.00**, made payable to the **Treasurer of Virginia**.

Disclosure of Addresses

Some licensees have expressed concern that their residence address is accessible. Consistent with Virginia law and the mission of the Department of Health Professions addresses of licensees are made available to the public. This has been the policy and the practice of the Commonwealth for many years. However, the application of new technology makes such information more accessible.

In most cases it is permissible for an individual to provide an address of record other than a residence, such as a Post Office Box or a practice location. Changes of address may be made at the time of renewal or at anytime by written notification to the appropriate health regulatory board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be mailed to the address provided.

PART A. IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	Maiden Name	
Street Address (include Apt. #)		City	State	Zip Code
Social Security # or Virginia DMV Control #	Virginia LNP #	Date of Birth	Telephone Number	

PART B. REQUIRED QUALIFICATIONS

Circle the number of ONE of the following and provide the documentation indicated:

1. Copy of document that verifies current professional certification as a nurse practitioner or nurse-midwife (such as ANCC, NCC or ACNM); **OR**
2. Transcript or letter sent to the Board of Nursing office from an educational program verifying satisfactory completion of a graduate level course in pharmacology or pharmacotherapeutics obtained as a part of your nurse practitioner or nurse-midwifery education within the past five years; **OR**
3. A statement from a superior or a personal affidavit in "Part F. EXPLANATIONS" on the back of this page attesting to no less than 1000 hours of practice in each of the last two years and copies of documents verifying 15 hours of continuing education in each of the last two years; **OR**
4. Evidence of 30 hours of education in pharmacology or pharmacotherapeutics taken within the last five years which includes applicable federal and state laws, prescription writing, drug selection, dosage, route and interactions, information resources, and clinical application related to your area of practice. This evidence must be either an official transcript from the institution offering a formal course or copies of documents verifying non-credit continuing education offerings.

Circle the number of your LNP category. If you have more than one NP license, circle each in which you wish to use prescriptive authority:

01 Adult
02 Family
03 Pediatric
07 Geriatric
09 Certified Nurse Midwife
13 Neonatalogy
14 Women's Health
16 Acute Care
17 Psychiatric

PART C. PRACTICE AGREEMENTS
Complete and submit. (See attached.)

PART D. EMPLOYER (If Applicable)

Name:

____

Address:

____

Name of Primary Supervising Physician (if different from above):

____

Address (if different from above):

____

PART E. ANSWER THE FOLLOWING QUESTIONS. If either is answered "YES," explain in "PART F" below:

1. Have you ever had disciplinary action taken against your license or certification in Virginia or any jurisdiction? YES ____ NO ____
2. Is there any investigation of you or action pending against you in Virginia or any other jurisdiction? YES ____ NO ____

PART F. EXPLANATIONS

PART G. AFFIDAVIT

TO BE COMPLETED BEFORE A NOTARY PUBLIC

State of ____________________________________ County/City of _______________________________

Name ______________________________________, being duly sworn, says that he/she is the person who is referred to in the foregoing application; that the statements contained herein are true; that he/she has complied with all requirements of the law, and that he/she has read and understands this affidavit.

____
Signature of Applicant

Sworn and subscribed to before me this _____ day of ______________________, __________.

____
Signature of Notary Public

SEAL My commission expires on : _____________________

Revised 06/24/11