

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@pa.gov

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

INITIAL APPLICATION FOR NURSE-MIDWIFE PRESCRIPTIVE AUTHORITY

* A separate prescriptive authority collaborative agreement must be submitted for each physician, physician group or service with which you will be entering into an agreement. If you currently hold a nurse-midwife prescriptive authority certificate and are requesting an additional prescriptive authority collaborative agreement, **DO NOT** use this form. Complete the form titled **Additional Prescriptive Authority Collaborative Agreement**.

REQUIREMENTS FOR CERTIFICATION:

1. Hold an active Pennsylvania Registered Nurse license.
2. Hold an active Pennsylvania Nurse-Midwife license.
3. Has entered into a collaborative agreement with a physician who holds an active unrestricted license under the State Board of Medicine or the State Board of Osteopathic Medicine.
4. Successful completion of not less than 45 hours of course work specific to advanced pharmacology from a college, university or medical/nursing school at a level beyond the basic professional nursing education program. The 45 hours may be achieved through a single 45-hour course or through two or more courses totaling 45 hours.
5. Successful completion of 16 hours of advanced pharmacology within 2 years immediately preceding the application for prescriptive authority.

PLEASE NOTE: If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.

YOU MAY NOT PRESCRIBE UNTIL YOUR APPLICATION IS COMPLETE AND THE BOARD ISSUES YOUR PRESCRIPTIVE AUTHORITY CERTIFICATE.

APPLICANTS MUST COMPLETE THE FOLLOWING:

1. Submit the \$70.00 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE. Check or money order must be in "US funds."** **Note:** A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.
2. Complete pages 1 and 2 of the application.
3. If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.).
4. Complete Section 1 of the Verification of Advanced Pharmacology form and send to the educational program where your advanced pharmacology coursework was completed. The school must complete Section 2 and then return the form directly to the Board in a sealed, official school envelope.

5.	Complete Section 1 of the Verification of Masters Degree Education form and send to the educational program where you received your Masters degree. Section 2 should be completed by the school/program. The program must return the completed form directly to the Board in an official school envelope.
6.	Complete the attached Collaborative Agreement for Nurse-Midwife Prescriptive Authority application.
RENEWAL REMINDER:	
In addition to renewing your RN and nurse-midwife licenses biennially, you will also be responsible for renewing the Prescriptive Authority Certificate.	

IMPORTANT INFORMATION	
1.	PLEASE FOLLOW ALL DIRECTIONS. ANY DISCREPANCIES WILL CAUSE A DELAY IN THE ISSUANCE OF A CERTIFICATE.
2.	IF THIS APPLICATION IS NOT COMPLETED WITHIN SIX MONTHS, <u>UPDATES OF CERTAIN SECTIONS AND/OR SUPPORTING DOCUMENTS WILL BE REQUIRED.</u>
3.	IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO THE BOARD OR RECEIVED FROM THE BOARD.
4.	YOU <u>MAY NOT</u> PRESCRIBE IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL A PRESCRIPTIVE AUTHORITY CERTIFICATION HAS BEEN ISSUED BY THE PENNSYLVANIA STATE BOARD OF MEDICINE.
5.	IN ORDER TO PRACTICE THIS PROFESSION IN THE COMMONWEALTH OF PENNSYLVANIA, YOU MUST MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE COVERAGE.
6.	ALL CERTIFICATIONS WILL EXPIRE DECEMBER 31ST OF AN EVEN-NUMBERED YEAR. THE EXPIRATION DATE IS NOT DETERMINED BY THE ISSUE DATE.
7.	THE FEE SUBMITTED WITH THIS APPLICATION IS A PROCESSING FEE. AT RENEWAL TIME, YOU WILL BE ASSESSED THE FULL RENEWAL FEE.
8.	IF THE APPLICATION PROCESS IS NOT COMPLETED WITHIN ONE YEAR, APPLICANTS WILL BE REQUIRED TO SUBMIT AN UPDATED APPLICATION (<u>ANOTHER APPLICATION PROCESSING FEE</u>) ALONG WITH SUPPORTING DOCUMENTS, AS NECESSARY.

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Submit the \$70 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** **Check or money order must be in "U.S. funds."** **Note:** A processing fee of \$20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.

TO BE COMPLETED BY APPLICANT (Please print or type)

NAME:	Last			First			Middle			
ADDRESS:	Street									
City				State				ZIP		
DATE OF BIRTH:	Month	Day	Year	SOCIAL SECURITY NUMBER:						
TELEPHONE NO:										
EMAIL ADDRESS:										
PA REGISTERED NURSE LICENSE NO:				PA NURSE-MIDWIFE LICENSE NO:						

If your supporting documents are listed under another name or names, please list below:

Last First Middle

NAME & ADDRESS OF ADVANCED PHARMACOLOGY & MASTERS DEGREE PROGRAM

1. NAME OF ADVANCED PHARMACOLOGY PROGRAM:												
ADDRESS OF PROGRAM:												
DATES ADVANCED PHARMACOLOGY COMPLETED:	FROM	Month	Day	Year	TO:	Month	Day	Year				
2. NAME OF MASTERS DEGREE PROGRAM:												
ADDRESS OF PROGRAM:												
DATE OF ATTENDANCE:	FROM	Month	Day	Year	TO	Month	Day	Year	DATE OF GRADUATION:	Month	Day	Year

LEGAL QUESTIONS

You must answer the following questions. If you answer "YES" to #2 through #12, provide complete details on a separate sheet as well as certified copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? If you answered yes, provide the profession and state or jurisdiction. LIST: _____		
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
8	Have you had your DEA registration denied, revoked or restricted?		
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11	Have you engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
12	Have you been the subject of a civil malpractice lawsuit? If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. **If you previously reported the complaint to the Board provide the docket number _____		

SIGNED STATEMENT

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards 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). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made 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, certificate, permit or registration.

Signature of Applicant

Date

Printed Name of Applicant

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF MASTERS DEGREE EDUCATION

Complete Section 1 and forward to the college/university where you completed your masters degree program.

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
ADDRESS:	Street		
City	State	ZIP	
NAME OF COLLEGE/UNIVERSITY:			
ADDRESS:	Street		
City	State	ZIP	

Submit the verification of masters degree education form to the university/school and request the school return the completed form directly to the board in an official school envelope.

**SECTION 2 – TO BE COMPLETED BY DEAN, REGISTRAR or
OFFICIAL OF MASTERS DEGREE PROGRAM**

NAME OF SCHOOL:			
NAME OF STUDENT:	Last	First	Middle
DATE STUDENT BEGAN TO ATTEND THIS MASTERS PROGRAM:	Month	Day	Year
DATE OF GRADUATION:	Month	Day	Year

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DEAN, REGISTRAR OR OFFICIAL OF AN ACCREDITED INSTITUTION OF HIGHER EDUCATION:			
DATE:	Month	Day	Year
(Seal of School)		<p>Upon completion, the school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.</p> <p align="center"><i>DO NOT RETURN THIS FORM TO THE APPLICANT</i></p>	

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PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF ADVANCED PHARMACOLOGY

Complete Section 1 and forward to the university/school where you completed at least 45 hours of course work in advanced pharmacology at a level beyond the basic professional nursing education.

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
ADDRESS:	Street		
City	State	ZIP	
NAME OF PROGRAM/SCHOOL:			
ADDRESS:	Street		
City	State	ZIP	

Submit the verification of advanced pharmacology form to the university/school and request that the school return the completed form directly to the board in an official school envelope.

SECTION 2 – TO BE COMPLETED BY DEAN, REGISTRAR or OFFICIAL OF SCHOOL/PROGRAM

NAME OF SCHOOL:									
NAME OF STUDENT:	Last			First			Middle		
DATES OF ADVANCED PHARMACOLOGY COURSEWORK:	FROM	Month	Day	Year	TO	Month	Day	Year	

I certify that the student listed above has completed at least 45 hours of coursework in advanced pharmacology at a level beyond the basic professional nursing education.

SIGNATURE OF DEAN, REGISTRAR OR OFFICIAL OF AN ACCREDITED INSTITUTION OF HIGHER EDUCATION:									
DATE:	Month	Day	Year	<p>Upon completion, the school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.</p> <p align="center">DO NOT RETURN THIS FORM TO THE APPLICANT</p>					
(Seal of School)									

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COLLABORATIVE AGREEMENT FOR NURSE-MIDWIFE PRESCRIPTIVE AUTHORITY

IMPORTANT APPLICATION INFORMATION

1. This application is only used for entering into the **first** prescriptive authority collaborative agreement. A separate prescriptive authority collaborative agreement must be submitted for each physician, physician group or service with which you will be entering into an agreement. A new application is required for each additional prescriptive authority collaborative agreement. To register additional prescriptive authority collaborative agreements, complete the application titled, **Additional Prescriptive Authority Collaborative Agreement**. If making changes to an existing prescriptive authority collaborative agreement, complete and submit the **Collaborative Agreement Change Form**.
2. This application may be used to enter into a prescriptive authority collaborative agreement with an allopathic or osteopathic physician licensed by the State Boards of Medicine or Osteopathic Medicine. The physician must have hospital privileges (or a formal arrangement for patient admission to a hospital) and shall practice in the specialty area of the care for which the physician is providing collaborative services.
3. **A copy of the prescriptive authority collaborative agreement must be submitted with this application.**
4. Pennsylvania law requires you to maintain a copy of this application as well as your prescriptive authority collaborative agreement.

YOU MAY NOT PRACTICE IN THE COMMONWEALTH OF PENNSYLVANIA AS A MIDWIFE WITH PRESCRIPTIVE AUTHORITY UNTIL YOU HAVE ENTERED INTO A PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT WITH A PHYSICIAN; FILED A COPY OF THE AGREEMENT WITH THE BOARD AND A PRESCRIPTIVE AUTHORITY CERTIFICATION HAS BEEN ISSUED BY THE BOARD.

PLEASE PRINT OR TYPE

NURSE-MIDWIFE NAME:	Last	First	Middle
NURSE-MIDWIFE LICENSE NO.:			
COLLABORATING PHYSICIAN NAME:	Last	First	Middle
PHYSICIAN LICENSE NO.:			

CHECK ALL OF THE CONTROLLED SUBSTANCE SCHEDULES THAT THE NURSE-MIDWIFE WILL PRESCRIBE and/or DISPENSE

<input type="checkbox"/> Schedule II	<input type="checkbox"/> Schedule III	<input type="checkbox"/> Schedule IV	<input type="checkbox"/> Schedule V
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LIST BELOW THE CATEGORIES OF DRUGS FROM WHICH THE NURSE-MIDWIFE MAY PRESCRIBE/DISPENSE AND ANY RESTRICTIONS THERETO. (IF YOU REQUIRE ADDITIONAL SPACE, PLEASE USE A SEPARATE SHEET OF 8 1/2" X 11" PAPER.)

<u>Categories CNM May Prescribe/Dispense</u>	<u>Restrictions</u>

This agreement contains the details of the prescriptive authority collaborative arrangement between myself and the below-signed collaborating physician with respect to the care of midwifery patients and the prescribing and dispensing of drugs.

NURSE-MIDWIFE SIGNATURE:		Date
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This agreement contains the details of the prescriptive authority collaborative arrangement between myself and the above-signed nurse-midwife with respect to the care of midwifery patients and the prescribing and dispensing of drugs. I attest that I have knowledge and experience with any drug that the nurse-midwife will prescribe and dispense.

COLLABORATING PHYSICIAN SIGNATURE:		Date
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