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**Instructions**  
**For Certified Registered Nurse Practitioner (CRNP) Prescriptive Authority Application**

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

**FAQs AND LAW/REGULATIONS**

- FAQs about Prescriptive Authority as well as the Professional Nursing Law and the Board's regulations can be found on the Board's website at [www.dos.pa.gov/nurse](http://www.dos.pa.gov/nurse).

**INSTRUCTIONS:**

- Mail the completed application and fee to the Board at the above address.
- All questions must be answered completely and all fees submitted in order for the application to be processed.
- To verify that the CRNP Prescriptive Authority was issued visit [www.licensepa.state.pa.us](http://www.licensepa.state.pa.us).
- Social Security Numbers must be provided.\* If a Waiver of Social Security Number form is submitted in lieu of a Social Security Number, it cannot be used to renew a CRNP Prescriptive Authority.
- Application 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.
- If a CRNP Prescriptive Authority is not issued within the one year, a new application, including fees, must be submitted.

**FEES:**

- The \$50.00 Initial Application and/or \$30.00 Additional Authority Application fee must be paid by personal check, cashier's check or money order and must be made payable to the "**Commonwealth of Pennsylvania.**"
- **Fees are nonrefundable.**
- 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 legal name must be entered on the application.
- A CRNP Prescriptive Authority is not forwarded.
- Complete and submit the "Form to Request Change of 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.

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

- A detailed, signed and dated personal explanation explaining the action, its background and any rehabilitation.
- A Criminal History Records Check (CHRC) from a State Law Enforcement Authority in all states where you lived in the last five years. All background check documents cannot be older than 90 days from the date of issuance. (Applicable ONLY to #B4 and #B5)
- Copies of criminal Court documents. (Applicable ONLY to #B4 and #B5)
- Certified copies of all disciplinary actions from the Boards that imposed action (Applicable ONLY to #B1, #B2 and #B3).

**CONTINUING EDUCATION:**

- Out of the 30 total hours, CRNPs with Prescriptive Authority must complete at least 16 hours of Board-approved continuing education in pharmacology in the 2-year period immediately preceding biennial renewal.
- As part of the biennial renewal application CRNPs are required to verify completion of the pharmacology hours.
- Refer to [www.dos.pa.gov/nurse](http://www.dos.pa.gov/nurse) for detailed information about this continuing education renewal requirement.

## **Application Submission Requirements:**

### **Applicants for INITIAL CRNP Prescriptive Authority in Pennsylvania must submit:**

- Form 1: An Application for CRNP Prescriptive Authority* signed by the applicant.
- Form 2: A copy of the Collaborative Agreement for CRNP Prescriptive Authority* signed by the applicant and the collaborating physician. The original Collaborative Agreement must remain at the primary practice location.
- Form 3: A Verification of Advanced Pharmacology Form* completed and mailed to the Board by the program director where the Advanced Pharmacology course was completed.
- A **\$50** fee for Initial Application.

### **Applicants for ADDITIONAL CRNP Prescriptive Authority in Pennsylvania must submit:**

- Form 1: An Application for CRNP Prescriptive Authority* signed by the applicant.
- Form 2: A copy of the Collaborative Agreement for CRNP Prescriptive Authority* signed by the applicant and collaborating physician. The original Collaborative Agreement must remain 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:**

- Include the Pennsylvania CRNP Certificate number on the prescriptive authority application (this begins with **SP-, VP-, TP-, or UP-**). Prescriptive authority cannot be granted to a CRNP applicant whose application has a "Pending" status.
- The National Certification Number is not required on this application.
- The application must include the Applicant's original signature and date signed; faxed, emailed, or scanned copies will not be accepted.

### **FORM 2: COLLABORATIVE AGREEMENT FOR CRNP PRESCRIPTIVE AUTHORITY:**

- Print the CRNP specialty **exactly as listed** on the Pennsylvania CRNP Certificate. Specialties should be verified at [www.licensepa.state.pa.us](http://www.licensepa.state.pa.us).
  - Professional liability insurance—Simply answer the question; **do not attach the insurance policy.**
- Collaborative/Substitute Physician
  - **Collaborative and substitute physicians must hold active Pennsylvania licenses.**
  - Ensure that collaborating and substitute physicians' names and license numbers are correct by verifying the information at [www.licensepa.state.pa.us](http://www.licensepa.state.pa.us)
  - **Include the entire license number** (prefixes/suffixes and zeros are part of a license number). **Include at least one substitute physician. Applications without a substitute** cannot be processed,
  - **If there are multiple substitute physicians, check "List of additional substitutes is attached"** and attach the list with each physician's name and license numbers. The CRNP and collaborating physician **must** be listed at the top of the attachment.
- Controlled Substance Prescribing Authority
  - Complete for each Schedule even if specific Schedules are not permitted.
  - 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**
- Make available, upon request, the original *Collaborative Agreement for CRNP Prescriptive Authority* at the primary practice location. A copy of the *Collaborative Agreement* should be maintained by the CRNP.
- A CRNP may not prescribe until the Prescriptive Authority Application is approved 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 for verification of the number of hours of advanced pharmacology content and specialty completed.
- The completed form must be mailed directly to the Board. Emailed, scanned or faxed copies will not be accepted.

**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 Number \_\_\_\_\_

**SECTION B: QUESTIONS:** ANSWER THE FOLLOWING QUESTIONS.

		YES*	NO
1.	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?		
2.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3.	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?		
4.	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.		

Name: \_\_\_\_\_

SSN: \_\_\_\_\_

YES

NO

5.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
6.	Do you currently engage in, or have you ever 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?		
7.	Have you ever had your DEA registration denied, revoked or restricted?		
8.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
9.	Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?		
10.	Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		

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

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. § 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.

Applicant's Full Legal Signature \_\_\_\_\_ Date \_\_\_\_\_

\*Note that 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 (DHS), the licensing boards must provide to DHS information prescribed by DHS 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.

**PENNSYLVANIA STATE BOARD OF NURSING**

P.O. BOX 2649  
HARRISBURG, PA 17105-2649  
PHONE: (717) 783-7142

**COLLABORATIVE AGREEMENT FOR CRNP PRESCRIPTIVE AUTHORITY**

1) **Name of Certified Registered Nurse Practitioner:** \_\_\_\_\_

**Pennsylvania CRNP Number:** \_\_\_\_\_

**CRNP Specialty exactly as listed on the Pennsylvania CRNP Certificate :** \_\_\_\_\_

**Professional Liability: Check one**

- I maintain the required professional liability insurance.
- I am exempt from having the required professional liability insurance.

2) **Collaborating Physician:** Name: \_\_\_\_\_

Pennsylvania License Number: \_\_\_\_\_  
(Include prefix/suffix)

**Substitute Physician:** Name: \_\_\_\_\_  
(At least one (1) substitute physician is required.)

Pennsylvania License Number: \_\_\_\_\_  
(Include prefix/suffix)

List of additional  
substitutes is  
attached

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Once per year  | <input type="checkbox"/> Every other visit         | <input type="checkbox"/> Patient not responding to treatment              |
| <input type="checkbox"/> Twice per year | <input type="checkbox"/> CRNP Request              | <input type="checkbox"/> Patient condition outside CRNP scope of practice |
| <input type="checkbox"/> Daily          | <input type="checkbox"/> Patient or Family request | <input type="checkbox"/> Other _____                                      |

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

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**COLLABORATIVE AGREEMENT FOR PRESCRIPTIVE AUTHORITY (continued)**

Name of Certified Registered Nurse Practitioner: \_\_\_\_\_

Pennsylvania CRNP Number: \_\_\_\_\_

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**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 The date you are requesting that this agreement become effective:** \_\_\_\_\_  
(mm/dd/yyyy)

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**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)

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# VERIFICATION OF ADVANCED PHARMACOLOGY

The following information must be completed by the director of the educational program or designee and must verify that the CRNP successfully completed at least 45 hours of course work in advanced pharmacology above the pharmacology course required by a professional nursing education program. **NOTE: If one course alone does not total 45 hours but advanced 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.**

Pennsylvania State Board of Nursing  
CRNP Prescriptive Authority Applications  
P.O. Box 2649  
Harrisburg, PA 17105-2649