

STATE BOARD OF NURSING

Mailing Address:
State Board of Nursing
P.O. Box 2649
Harrisburg, PA 17105

Telephone: 717-783-7142
Fax: 717-783-0822
Email: st-nurse@pa.gov
www.dos.pa.gov/nurse

Application for Renewal/Reactivation of a Pennsylvania CRNP Prescriptive Authority Approval that has been Expired or Inactive for Less Than 3 Years

This application cannot be used for the purpose of renewing a current license.

<p><u>Notice: Fee was increased on July 27, 2019.</u></p> <p>The non-refundable fee must be submitted in the form of a personal check, cashier's check, or money order made payable to the Commonwealth of Pennsylvania.</p> <p>A processing fee of \$20.00 will be charged for a check or money order returned unpaid.</p>	<p>Name _____ (Last) (First) (Middle)</p> <p>Maiden Name _____</p> <p>All last names you have used _____</p> <p style="text-align: center;">Notice: Licenses cannot be forwarded by post office.</p> <p>Current Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Telephone No. _____ Date of Birth _____ (Include the area code) (Month) (Day) (Year)</p> <p>Email Address _____</p> <p>U.S. Social Security No. _____</p> <p>PA CRNP No. _____ NPPA No. _____</p> <p>Collaborating Physician associated with this Prescriptive Authority: _____</p> <p>Expiration Date ____/____/____</p>
<p>Check the appropriate statement below.</p>	
<p><input type="checkbox"/> I have not practiced as a CRNP in Pennsylvania using this prescriptive authority at any time after my expiration date, and I want to reactivate my CRNP prescriptive authority approval at this time. Submit payment in the amount of \$41.00.</p>	
<p><input type="checkbox"/> I have practiced as a CRNP in Pennsylvania using this prescriptive authority at any time after my expiration date, and I want to reactivate my prescriptive authority approval at this time. Submit payment in the amount of \$41.00 for each biennial renewal cycle since your expiration date plus a late fee of \$5.00 per month for each month after your expiration date.</p>	

	YES	NO
1. Are you submitting a name change with this reactivation?		
<p>Change name to: You must submit a copy of a legal document verifying the name(s). The following are acceptable name change verification documents:</p> <ul style="list-style-type: none"> • Marriage Certificate • Divorce decree which indicates the retaking of your maiden name • Other "legal" document indicating the retaking of a maiden name • For a "legal" name change, a copy of the court document must be provided 		
2. With the exception of the one you are currently reactivating, 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?		
3. Please provide the profession and state or jurisdiction.		
<p>If you answer yes to questions 4, 5, and/or 6, provide copies of all disciplinary actions from the Boards that imposed actions and a personal detailed statement. If you answer yes to questions 7 and/or 8, provide copies of pertinent documents and a personal detailed statement.</p>		
4. Since your initial application or last renewal, whichever is later, 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?		
5. Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
6. Since your initial application or last renewal, whichever is later, 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?		
7. Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
8. Since your initial application or last renewal, whichever is later, 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?		
9. Have you completed at least 16 hours of Board-approved continuing education in pharmacology?		
10. Have you completed at least 2 hours of Board-approved education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids?		

Print your NAME: _____ NPPA No. _____

ACKNOWLEDGEMENT OF DUTY TO SELF-REPORT DISCIPLINARY CONDUCT AND CERTAIN CRIMINAL ACTIVITY

I, _____, hereby acknowledge that in addition to any existing reporting requirement required by a specific board or commission, I am REQUIRED pursuant to Act 6 of 2018 to NOTIFY the Bureau of Professional and Occupational Affairs WITHIN 30 DAYS of the occurrence of any of the following: (1) A disciplinary action taken against me by a licensing board or agency in another jurisdiction; (2) A finding or verdict of guilt, an admission of guilt, a plea of nolo contendere, probation without verdict, a disposition in lieu of trial or an Accelerated Rehabilitative Disposition (ARD) of any felony or misdemeanor offense in a criminal proceeding. I further acknowledge that failure to comply with these mandatory reporting requirements may subject me to disciplinary action by the Board. I acknowledge my understanding that to self-report a disciplinary action or criminal matter as set forth above, I may log in to the Pennsylvania Licensing System (PALS) at www.pals.pa.gov and select "Mandatory Reporting by Licensee" under the heading "Your Licenses."

Licensee Signature Date

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.

Licensee Signature Date

-
- There are NO changes to the CRNP Prescriptive Authority Collaborative Agreement in place at the time the Agreement lapsed or was placed on inactive status.
 - There ARE changes to the CRNP Prescriptive Authority Collaborative Agreement in place at the time the agreement lapsed or was placed on inactive status. **Submit a CRNP Prescriptive Authority Change Form for each area of the agreement being changed. These forms are located on the Board's website, www.dos.pa.gov/nurse. **

Signature of CRNP _____ Date _____

Printed name of CRNP _____

Signature of Collaborating Physician _____ Date _____

Printed name of Collaborating Physician _____ License No. _____

This application is valid for one (1) year from the date the application was signed. The process must be completed within this timeframe or you will be required to submit a new application and repay the reactivation fee.