



Oregon State Board of Nursing
 17938 SW Upper Boones Ferry Rd.
 Portland, OR 97224-7012
 971-673-0685
 www.oregon.gov/OSBN

Oregon Application for APRN Dispensing Authority

NOTE: Use only blue or black ink and print all information legibly. Faxed or emailed applications will not be accepted; an original application with signature is required.

Section 1: Application Type

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| <input type="checkbox"/> Applying for Oregon APRN prescriptive and dispensing authority at the same time. | <input type="checkbox"/> I have Oregon APRN prescriptive authority and am applying for dispensing authority. |
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Section 2: Applicant Information

Last Name:		First Name:	
Middle Name:		Former Name(s) Used:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (mm/dd/yyyy): / /		
Address:			
City:		State:	Zip:
Country:		Email:	
Primary Telephone: <input type="checkbox"/> Unlisted		Secondary Telephone: <input type="checkbox"/> Unlisted	
I prefer to be contacted by: <input type="checkbox"/> telephone <input type="checkbox"/> email <input type="checkbox"/> postal mail			

Section 3: Dispensing Prescription Drugs

- I have read the **Prescriptive and Dispensing Authority in Oregon for Advanced Practice Registered Nurses** handbook available on the OSBN website at <http://www.oregon.gov/OSBN> and will comply with regulations regarding APRN nurses who prescribe and dispense prescription drugs in Oregon.

Section 4: Authorization

I understand I have a duty to provide the Oregon State Board of Nursing with any updates to information required in this application while it is pending. I hereby certify that I have read this application, and that the information provided is true and correct. I have personally completed this application. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or discipline of license/certification. I am aware that the Oregon State Board of Nursing will conduct criminal records checks through the Oregon Law Enforcement Data System (LEDS) and the Federal Bureau of Investigation (FBI).

- I do not want my name and address shared with non-state agencies or for non-public health planning purposes. I understand this does not apply to requests made to OSBN for public information as authorized by ORS 192.420.

Applicant Signature	Date (mm/dd/yyyy):
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Mail completed application to: OSBN 17938 SW Upper Boones Ferry Rd, Portland OR 97224.

Notice to Applicants with Disabilities: If you have a disability and require special materials or assistance to complete this application, please contact OSBN at 971-673-0685. If you are hearing impaired, you may contact OSBN through the Oregon Relay Service at 1-800-735-2900

OSBN USE ONLY - Applicant Name (last name, first name)

OSBN USE ONLY - License Number & Expiration Date

OSBN USE ONLY - Policy Analyst Review
 Staff Signature: _____
 Approval Date: _____