



Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road • Portland, OR 97224-7012

Phone: 971-673-0685 • Fax: 971-673-0684 • Website/Verification: www.oregon.gov/OSBN

Nurse Practitioner Certification Information

ATTENTION

- You must have a current, unencumbered Oregon Registered Nurse (RN) license before you can be certified as a Nurse Practitioner (NP). If you are not currently licensed as an Oregon RN, or have not filed an application for Oregon RN licensure, you must do so. Your NP certificate and prescriptive authority can be issued simultaneously with your RN license when you have met all the requirements.
- You must hold a current, valid Oregon Nurse Practitioner (NP) certificate **before** you practice as a NP, sign your name, or use a card, initials or device indicating you are a NP. Failure to comply may result in a civil penalty up to \$5,000 under ORS 678.370.

Fee

Application	Fee	Explanation
Nurse Practitioner (NP)	\$150	Required to be certified as a Nurse Practitioner (NP) in Oregon.
Prescriptive Authority	\$75	Prescriptive Authority in Oregon. (Required for NP in Oregon.)
Prescriptive Authority Practicum Limited License	\$95	Oregon NP applying for Prescriptive Authority who does <u>not</u> have prior clinical prescribing practicum or Prescriptive Authority. (Contact OSBN for information.)
Criminal Background Check	\$52	Contact OSBN to obtain a National Criminal Background Check packet.
Re-Entry Limited License	\$95	Oregon NP who does not meet the nursing practice requirement for renewal of certification. (Contact OSBN for information.)

REQUIREMENTS

Education Requirement

You must have graduated from a NP program specific to the category in which you seek NP certification, and have a Master's degree in nursing. Oregon recognizes the following categories:

Acute Care	Geriatric	Pediatrics
Adult	Neonatal	Psychiatric / Mental Health
Family Practice	Nurse Midwife	Women's Health

Certain exceptions to the Master's degree apply for completion of programs before 1986. *Specialty preparation within a baccalaureate program does not meet the education requirements for Nurse Practitioners in Oregon.* NP program coursework completed after January 1, 1986 must be at the graduate level.

When did you graduate from your Nurse Practitioner (NP) program?

❖ Graduated before January 1, 1981?

- You can be licensed in Oregon with a RN license and proof of completion of a Nurse Practitioner program that meets all educational requirements. (See OAR 851-050-0001)
- You also must meet all practice requirements. Please note: Not eligible for re-entry.

❖ Graduated between January 1, 1981 and January 1, 1986?

- You can be licensed in Oregon with a RN license and proof of completion of a BSN *and* completion of an additional Nurse Practitioner program. (The NP part of the program must meet all educational requirements per OAR 851-050-001.)
- You also must meet all practice requirements. Please note: Not eligible for re-entry.

❖ Graduated after January 1, 1986?

- You can be licensed in Oregon with a RN license and must have a master's degree in nursing; no other degree accepted.
- Your master's degree program must also be NLNAC or CCNE accredited.
- The Nurse Practitioner part of your program must meet all educational requirements per OAR 851-050-0001.
- You may be eligible for re-entry if you do not meet the practice requirement.

Practice Requirement

You must have:

- Completed your NP education program within the past year; **or**,
- Completed your NP education program & practiced as a Nurse Practitioner at least 192 hours within the past two years; **or**
- Practiced at least 960 hours as a Nurse Practitioner within the last five years.
- As of July 1, 2005, prior practice as a registered nurse requirement for nurse practitioner applicants will be as follows:

All initial applicants must provide documentation of a minimum of 384 hours of registered nurse practice, which includes assessment and management of clients and is not completed as an academic clinical requirement or continuing education program. This requirement is waived for individuals practicing in the specialty area as a licensed certified nurse practitioner in another state for at least 384 hours in the advanced practice role.

Prescriptive Authority Requirement

You must apply for and meet the requirements for prescriptive authority as part of this application.

National certification is not required. Certification from any national organization is not required in Oregon and will not be accepted in lieu of educational requirements.

Renewal Information

- **RN and NP.** Both licenses will be issued simultaneously and both must be unencumbered in Oregon.
- **Practice Requirement.** Practice as a NP for no less than 960 hours within the five years before the renewal expiration date or have completed a preceptorship. Falsification of practice hours is grounds for disciplinary action.
- **Continuing Education Requirement with Prescriptive Authority.** Documentation of 100 contact hours must be supplied with each renewal application. At least 50% of these hours must be CME or CE accredited. Hours submitted must include at least 15 hours of pharmacologic content. A form is available on the OSBN website for your use or may be requested. These CE hours are subject to random audits. Falsification of continuing education is grounds for disciplinary action. The form for CE records must be maintained for five years from date submitted to the Board.

For more information please visit the Continuing Education Frequently Asked Questions (FAQ) page of the OSBN website at www.oregon.gov/OSBN/advanced_practice_FAQs . New graduates who have graduated less than two years previous to application date will have CE hours prorated from the date of graduation.

- **No Grace Period.** An applicant whose NP certification is expired may not practice as a NP until certification is complete, subject to civil penalty.



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Nurse Practitioner Application Checklist

- Have a current Oregon Registered Nurse (RN) license.** If you do not have current RN licensure, ensure that the process is completed.
- Complete the application for certification as a Nurse Practitioner (NP).**
 - Use your legal name on the application. It will be the name on your license and must be the same name used on your RN license.
 - Applications not completed within one calendar year become void. After one year, you must complete a new application and pay another fee.
 - Complete and sign the application. Applications received without a signature will not be accepted.
- Complete the additional application for Prescriptive Authority.**
 - Read the booklet entitled, *Prescriptive Authority in Oregon for Nurse Practitioners and Clinical Nurse Specialists*. The required confirmation statement postcard is also available as the last two pages of the booklet which can be printed out, signed and included with your application documents.
 - Sign and return the postcard attesting knowledge of Oregon and federal pharmacy law.
- Photocopies of your current RN and NP license(s)** with the application if you are licensed as a NP in another state.
- Mail applications and non-refundable fee to the Oregon State Board of Nursing (OSBN).**

If you are applying for more than one category of NP certification, you must use a separate application and pay a fee for each category. *Please note: Only one Prescriptive Authority application is required per person.*
- Mail request for an official, final transcript from your Masters degree program.**

The official transcript must be mailed directly from your Masters degree program to OSBN. If your NP program was not within your masters program, request that an official transcript also be mailed from your NP program to OSBN. The transcript must be imprinted with an official seal, bear the appropriate Registrar's signature and must show completion date and degree granted. A **Licensure Transcript Request** form is included with this application packet for your convenience.
- Mail the *Verification of Successful Completion of an Advanced Practice Nursing Program* form to the school where you obtained your NP education.** Request that the form be completed and mailed directly to the OSBN with the required attachments of the program requirements and course descriptions matching your transcript.
- Contact OSBN at 971-673-0685 to obtain a National Criminal Background Check packet.**

Notice to Applicants with Disabilities: *If you have a disability and require special material or assistance, please contact the Board office 971-673-0685. If you are hearing impaired, you may reach the OSBN through the Oregon Relay Service, 1-800-735-2900.*



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Licensure/Certification General Information

Please Note

If you held an Oregon nursing license/certificate in the past, call the Oregon State Board of Nursing (OSBN) office and ask for information about reactivation.

Application

- Apply for licensure/certification well in advance of employment in Oregon. In some cases, it can take several weeks for information from schools and other agencies to arrive for processing. If you meet the requirements for licensure/certification, your license will be issued approximately five business days after we have reviewed all of the required information and have determined eligibility.
- OSBN may deny licensure/certification to an applicant convicted of certain crimes. If you have a criminal history, you will need to report it on your application and attach explanatory information on a separate sheet of paper. Falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of licensure/certification. A positive criminal record check will require investigation and may delay processing. Practicing before you are licensed/certified may result in a civil penalty.
- Your license/certification will be issued using the name on the initial application. If you change your name before or after issue, submit legal documentation of your name change.
- Your mailing address must be complete and current with OSBN at all times.

Fees

- Fees are non-refundable and processed on receipt. Even if you do not complete the application process or do not qualify for licensure/certification, the fee is not refundable. The fee pays for processing the application and, if you are eligible, issuing the license/certificate.
- A canceled check is your receipt and notification that OSBN has received the application.

Renewal

- Oregon uses a biennial birth date renewal system. When you receive your license/certificate, please note the expiration date. The expiration date is the midnight before your birthday in an odd year if you were born in an odd year or in an even year if you were born in an even year. Because of this, your first license/certificate may be valid anywhere from 60 days to two years and 59 days depending upon when you were born and when your application is complete. After that, if renewed on schedule, your license/certificate is good for two years.
- Your license is valid until the expiration date noted on the OSBN License Verification system at <http://www.oregon.gov/OSBN>. There is no grace period permitting practice beyond this expiration date.
- You will renew all licenses/certificates simultaneously.
- Notify OSBN in writing when you change your address to prevent delays in receiving your renewal notice.

Additional Information

- Refusal to provide a Social Security Number (SSN) may result in denial of license/certification issuance or renewal. This record of your SSN will be used for child support enforcement, tax administration purposes (including identification) and criminal background checks only, unless you authorize other use. If any disciplinary action is taken against your license/certification, your SSN will be reported to the federal Health Care Integrity and Protection Data Bank. Authority: ORS 25.785, ORS 305.385, USC Section 666 (a)(13).
- If you have a disability that requires special materials or assistance, please contact OSBN at 971-673-0685. If you are hearing impaired, you may reach OSBN through Oregon Relay Service, at 1-800-735-2900.
- Information about nursing practice in Oregon can be found at the OSBN web site at www.oregon.gov/OSBN
- Call OSBN at 971-673-0685 if you need additional information.
- License/certificate verification is available at <http://www.oregon.gov/OSBN>.



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Please use a black pen or pencil. Avoid "gel" pens, as they bleed through paper.

Nurse Practitioner Application

For office use only

Fee Owed For this Application:

\$ 150.00

The above fee is non-refundable and applies only for this application for Nurse Practitioner. Checks should be made payable to the Oregon State Board of Nursing.

Section 1: License Type

For which NP specialty are you applying?

- Acute Care Geriatric Pediatric
Adult Neonatal Psy / Mental Health
Family Nurse Midwife Women's Health

Section 2: Name & Address

Last Name:

First Name: Middle Name:

Former/Maiden Name(s):

Address:

City: State: Zip Code:

Email:

Home Telephone: Work Telephone: Unlisted? Yes No

Section 3: Personal Identifiers

Date of Birth (mm/dd/yyyy): Country of Birth:

City of Birth: State of Birth Gender: Female Male

Social Security Number:

(Refusal to provide a Social Security Number (SSN) will result in denial of license/certificate issuance or renewal. This record of your SSN will be used for child support enforcement and tax administration purposes (including identification) only, unless you authorize other use. If any disciplinary action is taken against your license/certificate, your SSN will be reported to the federal Health Care Integrity and Protection Data Bank. Authority: ORS 25.785, ORS 305.385, USC 666(a)(13).)

Consultant's Approval Date
RN License # Adv Prx License #

Section 4: Oregon Registered Nurse obtained By:

You must have a current, unencumbered Oregon RN license before obtaining NP certification. Please check which RN license application you have on file or are filing.

- Renewal
- Reactivation
- Endorsement
- Examination

Original State : _____

Section 5: Original License Information

List all states in which you have ever been licensed as a NP. If none, check here:

____ License type State License number

____ License type State License number

____ License type State License number

____ License type State License number

____ License type State License number

____ License type State License number

Section 6: Advanced Practice Legal / Discipline

Please provide a detailed explanation of any "Yes" answers on a separate sheet of paper.

1. Do you have a physical, mental or emotional condition that in any way impairs or may impair your ability to practice nursing with reasonable skill and safety? YES (Explain) NO

2. Have you ever been arrested, charged with, entered a plea of guilty, no contest, convicted of or been sentenced for any criminal offense either misdemeanor or felony, including driving under the influence, in any state? YES (Explain) NO

3. Have you ever been investigated for any type of abuse in any state? YES (Explain) NO

4. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? YES (Explain) NO

5. Are any disciplinary actions pending against your nursing license/certificate in any state or US jurisdiction? YES (Explain) NO

6. Have any disciplinary actions been taken against your nursing license/certificate in any state or US jurisdiction? YES (Explain) NO

7. Have you ever suffered any civil judgement for incompetence, negligence or malpractice concerning the practice as a health care professional? YES (Explain) NO

8. Do you use, or have you used in the last five years, chemical substance(s) in any way, which impairs or limits your ability to perform as a nurse with reasonable skill and safety? (*"Chemical Substance" includes alcohol and drugs.*) YES (Explain) NO

9. Are you currently engaged in the unlawful use of controlled substance(s)? (*Unlawful use of controlled substances means the use of controlled substances obtained illegally (e.g. marijuana, meth, heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care provider.*) YES (Explain) NO

10. Have you ever been found in any civil, administrative or criminal proceeding to have:
 - a. Possessed, used, prescribed for use or distributed controlled substances or prescription drugs in any way other the legitimate or therapeutic purposes, diverted controlled substances or prescription drugs, violated any drug law or pi controlled substances for yourself? a. YES (Explain) NO
 - b. Committed any act involving dishonesty or corruption? b. YES (Explain) NO
 - c. Violated any state or federal law or rule regulating the practice of a health care profession? c. YES (Explain) NO

11. Have you had any certificate, license, registration or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, censured or placed on probation by a state, federal, foreign authority or facility, or have you ever surrendered such credential in connection with or to avoid action by such authority? YES (Explain) NO

12. Have you ever had privileges to practice in a credentialed facility or participation in a federally qualified insurance program (such as Medicaid or Medicare) denied, restricted, suspended, revoked or terminated? YES (Explain) NO

Section 7: NP Education History

- Please complete the requested information for all education programs being submitted for Advanced Practice eligibility.
- Please do not attach resume and do not list individual coursework.
- Request your RN and NP program / schools to send your official transcript directly to the OSBN for processing.
- Begin with most recently completed education program and work backwards in time.

School Name _____		
City _____	State _____	Country _____
Degree/Certificate Earned:		
<input type="checkbox"/> LPN/LVN Certificate	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Doctorate Degree
<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor's Degree in Nursing	<input type="checkbox"/> Doctorate Degree in Nursing
<input type="checkbox"/> Associates Degree	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Post-Master's Certificate
<input type="checkbox"/> Associates Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing	<input type="checkbox"/> Other
_____/_____/_____	_____/_____/_____	_____
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)	Major
Name Listed on Transcript _____		Specialty/Type _____

School Name _____		
City _____	State _____	Country _____
Degree/Certificate Earned:		
<input type="checkbox"/> LPN/LVN Certificate	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Doctorate Degree
<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor's Degree in Nursing	<input type="checkbox"/> Doctorate Degree in Nursing
<input type="checkbox"/> Associates Degree	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Post-Master's Certificate
<input type="checkbox"/> Associates Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing	<input type="checkbox"/> Other
_____/_____/_____	_____/_____/_____	_____
Date Enrolled (mm/dd/yyyy)	Date Graduated (mm/dd/yyyy)	Major
Name Listed on Transcript _____		Specialty/Type _____

Section 8: NP National Certification(s)

Note: Your national certifying body must provide the Oregon State Board of Nursing with official written or electronic verification of your certification(s).

Certifying Body _____	<input type="checkbox"/> Acute Care	<input type="checkbox"/> Geriatric	<input type="checkbox"/> Pediatric
Expiration Date: ____/____/_____	<input type="checkbox"/> Adult	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Psy / Mental Health
	<input type="checkbox"/> Family	<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Women's Health
<hr/>			
Certifying Body _____	<input type="checkbox"/> Acute Care	<input type="checkbox"/> Geriatric	<input type="checkbox"/> Pediatric
Expiration Date: ____/____/_____	<input type="checkbox"/> Adult	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Psy / Mental Health
	<input type="checkbox"/> Family	<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Women's Health
<hr/>			
Certifying Body _____	<input type="checkbox"/> Acute Care	<input type="checkbox"/> Geriatric	<input type="checkbox"/> Pediatric
Expiration Date: ____/____/_____	<input type="checkbox"/> Adult	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Psy / Mental Health
	<input type="checkbox"/> Family	<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Women's Health

Section 9: RN and NP Nursing Practice History

- Please complete the requested information for all of your nursing practice, paid or unpaid, for the last five years.
- You may submit a narrative explanation of your nursing practice, as long as it contains the same information requested on this form.
- Begin with your most recent employer and work backwards in time.
- You may make additional copies as necessary.

_____		(____)____-____	
Company Name		Telephone number	
_____		_____	
Address		License number State	
_____		_____	
City	State	Zip code	Position Title
____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	# Practice Hours _____
Start Date (mm/dd/yyyy)	Still Employed?	End Date (mm/dd/yyyy)	Paid practice?: <input type="checkbox"/> Yes <input type="checkbox"/> No

_____		(____)____-____	
Company Name		Telephone number	
_____		_____	
Address		License number State	
_____		_____	
City	State	Zip code	Position Title
____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	# Practice Hours _____
Start Date (mm/dd/yyyy)	Still Employed?	End Date (mm/dd/yyyy)	Paid practice?: <input type="checkbox"/> Yes <input type="checkbox"/> No

_____		(____)____-____	
Company Name		Telephone number	
_____		_____	
Address		License number State	
_____		_____	
City	State	Zip code	Position Title
____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	# Practice Hours _____
Start Date (mm/dd/yyyy)	Still Employed?	End Date (mm/dd/yyyy)	Paid practice?: <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 9: Certifying Statement

I hereby certify that I have read this application, that I have personally completed this form, and that the information provided on this form is true, correct, and complete to the best of my knowledge. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of licensure/certification. I understand that licensing and certification are subject to meeting all qualifications and standards as provided in Oregon Revised Statutes and Oregon Administrative Rules. I am aware that the Oregon State Board of Nursing will conduct a criminal records check through the Law Enforcement Data System (LEDS). I am aware that if any disciplinary action is taken against my license, my social security number will be reported to the federal Health Care Integrity and Protection Data Bank.

Printed Name: _____ Date (mm/dd/yyyy): ____/____/____

Signature: _____

(Application will not be processed without signature.)



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Verification of Successful Completion of Advanced Practice Nursing Program (APRN)

Please type or print clearly using blue or black ink both front and back of application

Attach program requirements and course descriptions matching transcript of student.

Section I: To be completed by the Applicant. Complete Section I and then mail this form to educational institution to complete Section II for program verification.

Last Name First Name Middle Name Former or Maiden

Social Security Number (optional) or School Identification Number

Mailing Address City State Zip Code

()

Area Code Home Telephone Unlisted Email Address

I authorize my school program to release the information requested below to the Oregon State Board of Nursing.

Signature Date

Section II: To be completed by the Program. Complete the remainder of this form with responses for the time during which the applicant was enrolled. Please mail the completed form to the Oregon State Board of Nursing.

Certificate/Degree Awarded (Specify) Date Awarded

Name of School

School Mailing Address City State Zip Code

School Accreditation (Name of agency or association) Approval Date Expiration Date

Lecture/Didactic (Total number of classroom hours or academic credits awarded)

Supervised Clinical Practice (Number of hours) Clinical Site

Practicum included 150 or more hours of differential diagnosis and applied pharmacological management of individual patients? Yes No; Approximate number of hours completed

Name and Title of Program Advisor/Director Contact telephone number

Section II (Continued):

In order to assist the Oregon State Board of Nursing in evaluating the eligibility of the above applicant, who graduated from your program, please affirm that the program met the following criteria at the time the student attended.

If applicant was prepared as a Nurse Practitioner list specialty: _____

Program Information : The course numbers must match transcript awarded for time period applicant enrolled. Attach a copy of the **□** program requirements.

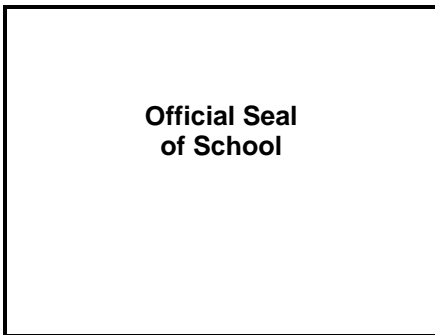
- 1. Was the program at least one academic year in length? YES NO
- 2. Did the program include theory in the biological, behavioral, nursing and medical sciences? YES NO
- 3. Did the applicant have clinical experience with a qualified preceptor? YES NO
- 4. Are the philosophies, purposes and objectives clearly defined and available in written formats? YES NO
- 5. Were the objectives stated in behavioral terms and do they describe the competencies of the graduate? YES NO
- 6. Did faculty include currently practicing advanced practice nurses? YES NO
- 7. Were records of the program, philosophy, objectives, administration, faculty, curriculum, students and graduates maintained systematically? YES NO
- 8. Are the records of the program retrievable? YES NO

Curriculum : Identify the course(s) where the following content/skills were taught correlating with transcripts. Attach a copy of the **□** course descriptions for the program matching the transcripts.

- | | Specific Course Number
(N/A if not applicable) |
|---|---|
| 1. Theory and directed clinical experience in physical assessment. | _____ |
| 2. Interviewing and communication skills relevant to obtaining and maintaining a health history. | _____ |
| 3. Pharmacology, including selecting, prescribing, initiating, and modifying medications in the management of health/illness. | _____ |
| 4. Advanced physiologic and pathologic mechanisms of disease. | _____ |
| 5. Performance and interpreting specialized diagnostic tests essential to the area of advanced practice. | _____ |
| 6. Differential diagnosis pertinent to the specialty area. | _____ |
| 7. Professional socialization and/or role realignment. | _____ |
| 8. Legal implications of the advanced nursing practice. | _____ |
| 9. Health delivery systems, including assessment of community resources and referrals to appropriate professionals or agencies. | _____ |
| 10. Research and statistical methods. | _____ |

I attest that this nurse was educated for advanced practice in (clinical area) _____

With the role of Certified Registered Nurse Anesthetist Clinical Nurse Specialist Nurse Practitioner.



Print Name ()
Telephone Number

Title _____

Signature _____



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Licensure Transcript Request

Section I : To be completed by applicant

Make as many copies as needed to request transcripts from the schools attended. Most schools require a fee to prepare a transcript. To avoid delays, contact your school(s) and inquire about the fee.

Send this form with Section I completed and the fee to the school.

Applicant Name : _____

Mailing Address : _____

City, State, and Zip Code : _____

Contact Telephone Number : () _____

Name on transcript : _____

Date of Birth : _____

Social Security Number : _____

Year of Graduation : _____

Degree Attained : _____

Signature of Applicant

Date Signed

Section II : Instructions for the school Registrar's office

Please attach this Transcript Request to the transcript. The request may contain a current name that is different from the name on the transcript. **The transcript must show the school's official seal, bear the appropriate Registrar's signature, degree awarded, and date the degree was awarded.**

Please send official transcripts directly by mail to:

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Prescriptive Authority Information

Attention

You must have either a current, unencumbered Nurse Practitioner (NP) or Clinical Nurse specialist (CNS) certification in Oregon, or apply for and meet the requirements for prescriptive authority concurrent with your application for NP or CNS certification.

Fee

Fees paid to the Oregon State Board of Nursing (OSBN) are not refundable. The application fee for Prescriptive Authority in Oregon is \$75.00.

Please note: *If a Prescriptive Authority Practicum Limited License is required, the separate Prescriptive Authority Practicum Limited License application and an additional \$95.00 will need to be submitted.*

If you have current prescriptive authority:

- If you have current prescriptive authority in another state, U.S. jurisdiction, federal institution or facility and **have** been prescribing or utilizing prescriptive authority at least 400 hours in the last two years, submit a completed Prescriptive Authority application and application fee.
- If you have current prescriptive authority in another state, U.S. jurisdiction, federal institution or facility but have not been prescribing or utilizing prescriptive authority at least 400 hours in the last two years, please contact the OSBN for instructions.

If you have never had prescriptive authority:

Please review the following three scenarios to determine which application(s) to submit to the OSBN for processing.

Scenario One

I graduated from an NP or CNS program within the past two years which included a 45 contact hour pharmacology course and clinical practicum in prescribing for individual patients of at least 150 hours.

I need to send :

- 1) Prescriptive Authority application

Scenario Two

I graduated from an NP or CNS program within the past two years which included a 45 contact hour pharmacology course but the program did *not* have clinical practicum in prescribing for individual patients.

I need to send :

- 1) Prescriptive Authority application
- 2) Prescriptive Authority Practicum Limited License application (*Contact OSBN for this additional application*)
- 3) Preceptor Agreement for Clinical Practicum in Pharmacological Management form
- 4) Clinical Practicum in Pharmacological Management Evaluation form (*This form to be completed and submitted when clinical practicum has been completed.*)

Scenario Three

I graduated from an NP or CNS program more than two years ago.

I need to send :

- 1) Prescriptive Authority application
- 2) Prescriptive Authority Practicum Limited License application (*Contact OSBN for this additional application*)
- 3) Preceptor Agreement for Clinical Practicum in Pharmacological Management form
- 4) Proof of completion of 45 hour pharmacology course within the past 2 years
- 5) Clinical Practicum in Pharmacological Management Evaluation form (*This form to be completed and submitted when clinical practicum has been completed.*)

How To Meet Oregon Prescriptive Authority Requirements

Oregon requires education and clinical practicum to meet the requirements for prescriptive authority. The following may be used to meet the requirement. To help avoid delay in processing your application, please *provide applicable documentation with your Prescriptive Authority application.*

Pharmacotherapeutic Education Requirement

1) Completion of a 45 hour pharmacology course including content congruent with the specialty scope of practice (NP or CNS) sought in Oregon. I have met this requirement through one of the following:

- a) Graduation from an NP or CNS program within two years prior to application which included a 45 contact hour pharmacology course that meets Oregon's requirements. *Please provide official transcript with Prescriptive Authority application; or*
- b) Completion of a 45 contact hour pharmacology course which meets Oregon's requirements within two years prior to application. *Please provide official transcript or photocopy of certificate of completion with Prescriptive Authority application; or*
- c) Current prescriptive authority in a state or US jurisdiction, including a federal institution or facility **and**
 - A 30 contact hour course completed to obtain current prescriptive authority which is congruent with the specialty role sought **with**
 - An additional 15 hours of CE in pharmacological management congruent with the specialty role sought completed within the last two years. *Please provide official transcript or photocopy of certification of completion with Prescriptive Authority application.*

Pharmacotherapeutic Clinical Practicum

2) Pharmacotherapeutic clinical practicum must be completed after the pharmacology course under direct supervision of a Medical Doctor (MD/DO), NP, or CNS with current Oregon prescriptive authority. I have met the clinical practicum requirement through one of the following:

- a) Completion of a directly supervised clinical practicum of no less than 150 hours which includes differential diagnosis and applied pharmacological management of patients congruent with the specialty sought.
 - Completed as part of a CNS or NP academic program.
 - Completed as part of a practicum outside of original academic program. *Please provide completed Verification of Clinical Practicum in Pharmacological Management form with Prescriptive Authority application and supporting transcripts or CE documentation of completion.*
- b) Proof of current prescriptive authority in another state, U.S. jurisdiction, federal institution or facility with practice including use of prescriptive authority of at least 400 hours within the last two years.

Additional information

- Read the booklet titled, *Prescriptive Authority in Oregon for Nurse Practitioners and Clinical Nurse Specialists*. This booklet is available online at www.oregon.gov/OSBN/pdfs/publications/prescriptive_booklet.pdf The required confirmation statement postcard is also available as the last two pages of the booklet which can be printed out, signed and included with your application documents.
- If your pharmacology coursework is not clearly indicated in transcripts sent to the Board, please provide a course description and documentation defining how you meet the Oregon requirement.
- Oregon does not accept integrated pharmacology.
- A list of approved pharmacology continuing education courses can be found on the OSBN website at www.oregon.gov/OSBN/pdfs/ApprovedPharmCourses.pdf OSBN will mail a list of approved pharmacology continuing education courses upon request.



Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road • Portland, OR 97224-7012
Phone: 971-673-0685 • Fax: 971-673-0684 • Website/Verification: www.oregon.gov/OSBN

Prescriptive Authority Application Checklist

- Have a current Oregon Registered Nurse (RN) license.** If you do not have current Oregon RN licensure, ensure that the process is completed.
- Photocopies of your current RN, NP and/or CNS prescriptive authority license(s)** with the application if you are licensed in another state, if applicable.
- Complete the application for Prescriptive Authority.**
 - Read the booklet titled, *Prescriptive Authority in Oregon for Nurse Practitioners and Clinical Nurse Specialists*. This booklet is available online at www.oregon.gov/OSBN/pdfs/publications/prescriptive_booklet.pdf The required confirmation statement postcard is also available as the last two pages of the booklet which can be printed out, signed and included with your application documents.
 - Sign and return the confirmation statement postcard attesting knowledge of Oregon and federal pharmacy law. The required confirmation statement postcard is also available as the last two pages of the booklet which can be printed out, signed and included with your application documents.
 - Complete and sign the application. Applications received without a signature will not be accepted.
- Mail application(s) and non-refundable application fee(s) to OSBN for processing.** If you also need to apply for a Limited License for Prescriptive Authority Practicum, contact the OSBN for the additional application.
- Mail request to your school(s) for an official, final transcript and/or attach photocopies of certificate(s) of completion showing satisfactory completion of required coursework.** The official transcript must be mailed directly from your NP or CNS degree program to OSBN. The transcript must be imprinted with an official seal, bear the appropriate registrar's signature and must show completion date and degree granted. A **Licensure Transcript Request** form is included with this application packet for your convenience.



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Please use a black pen or pencil. Avoid "gel" pens, as they bleed through paper.

Prescriptive Authority Application

For office use only

FEE OWED FOR THIS APPLICATION:

\$ 75.00

The above fee is non-refundable and applies only for this application for Prescriptive Authority. Checks should be made payable to the Oregon State Board of Nursing.

SECTION 1: LICENSE TYPE

For which license are you applying? [] CNS Initial \$75.00 fee [] NP adding Prescriptive Authority to CNS (No fee)
[] NP Initial \$75.00 fee [] NP adding additional specialty/category (No fee)

SECTION 2: NAME & ADDRESS

Last Name: _____
First Name: _____ Middle Name: _____
Former/Maiden Name(s): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____
Home Telephone: (____) _____ - _____ Unlisted? [] Yes [] No
Work Telephone: (____) _____ - _____

SECTION 3: PERSONAL IDENTIFIERS

Date of Birth (mm/dd/yyyy): ____/____/____ Country of Birth: _____
City of Birth: _____ State of Birth ____ Gender: [] Female [] Male
Ethnicity: [] African American/Black [] Caucasian/White
[] American Indian/Alaska Native [] Hispanic or Latino
[] Asian (e.g., Filipino, Japanese, Chinese, etc.) [] Native Hawaiian/Other Pacific Islander
[] Multi-ethnic or racial background

Social Security Number: _____ - _____ - _____

(Refusal to provide a Social Security Number (SSN) will result in denial of license/certificate issuance or renewal. This record of your SSN will be used for child support enforcement and tax administration purposes (including identification) only, unless you authorize other use. If any disciplinary action is taken against your license/certificate, your SSN will be reported to the federal Health Care Integrity and Protection Data Bank. Authority: ORS 25.785, ORS 305.385, USC 666(a)(13).)

Consultant's Approval _____ Date _____
RN License # _____ Adv Prx License # _____

SECTION 4: PRACTICE INFORMATION

Please provide the primary location you will be utilizing your prescriptive authority in Oregon. If there will be additional locations of practice, please attach a separate piece of paper that includes the additional location information.

Primary Practice Name _____	(_____) _____ - _____ Telephone number
Address _____	
City _____	State _____ Zip code _____

SECTION 5: FEDERAL DRUG REGISTRATION

Please complete the following section to provide information about the status of your DEA registration / number.

I have Prescriptive Privilege in another state. No Yes _____
State State State

I have a DEA number. No
 Yes DEA number _____

Pending. I will send a photocopy of my DEA registration to the OSBN when I receive it.

Please mail a photocopy of your DEA registration to the OSBN or fax a photocopy of your DEA registration to (971)673-0684, Attention: Advanced Practice Consultant.

SECTION 6: CURRENT PRESCRIPTIVE AUTHORITY

If you have current unencumbered prescriptive authority in any state or US jurisdiction, including a US federal institution or facility and 400 hours utilizing prescriptive authority within the last 2 years, please check all the following that apply.

- Prescribing for individual patients
- Prescribing for populations
- Establishing and/or approving standing orders and protocols for drug therapy
- Active membership of a state, facility, or professional formulary committee which determines drug selection recommendations
- Investigator for drug studies
- Teaching pharmacology at the advanced nursing level
- Conducting and publishing research with a primary focus on patient management through drug therapy
- Expert consultation regarding prescribing standards and practice
- Other (Please specify) _____

NOTICE: You must read the Prescriptive Authority in Oregon booklet and then sign and return the enclosed signature postcard with your Prescriptive Authority application.

SECTION 7: CERTIFYING STATEMENT

I hereby certify that I have read this application, that I have personally completed this form, and that the information provided on this form is true, correct, and complete to the best of my knowledge. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of licensure/certification. I am aware that the Oregon State Board of Nursing will conduct a criminal records check through the Law Enforcement Data System (LEDS). I am aware that if any disciplinary action is taken against my license, my social security number will be reported to the federal Health Care Integrity and Protection Data Bank.

Printed Name: _____ Date (mm/dd/yyyy): _____ / _____ / _____

Signature: _____

(Application will not be processed without signature.)



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Verification of Current Licensure

RN LPN CNS CRNA NP

Use a separate form for each license type being verified.

SECTION 1

To be completed by applicant. Then, send to the state where you currently hold or last held a license used to practice Nursing. If your original state of licensure is the same state you are currently practicing disregard this form. Send this form only if the state does not participate in NURSIS. Many states charge a fee to generate a verification of licensure.

Last Name (Please print) _____ First Name _____ Middle Name _____

All former names and aliases (If none, indicate NONE) _____ Area Code () _____ Home Telephone Unlisted _____

Current State License Number _____ Date of Birth _____ Social Security Number -- -- _____

Mailing Address _____ City _____ State _____ Zip Code _____

I hereby authorize the state for where I last held a license used to practice to furnish the information requested below. The state is: _____

(Current State)

I also authorize my contact information to be updated. YES NO

Signature of Applicant _____ Date of Signature (mm/dd/yyyy) _____

SECTION 2

To be completed by Board Officials. Please mail the completed verification in a secure envelope directly to the Oregon State Board of Nursing.

License Number: _____ License Original Issue Date: _____

Applicant licensed by: Exam Endorsement Waiver Equivalency

Status of license: Current Expired Expiration Date: _____

Is license encumbered in any way? YES NO (If YES, please explain on back of form.)

Revoked Suspended Surrendered Restricted Probation

Board Seal

I hereby certify that the above is true and correct as recorded in the files of this office.

Signature: _____

Title: _____

State _____ Date _____



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Verification of Current Licensure

RN LPN CNS CRNA NP

Use a separate form for each license type being verified.

SECTION I

To be completed by applicant. Then send to the state where you currently hold or last held a license used to practice nursing. If your original state of licensure is the same state you are currently practicing disregard this form. Send this form only if the state does not participate in NURSYS. Many states charge a fee to generate a verification of licensure.

First Name _____ Middle Name _____ Last Name _____

()

All other names and aliases (If none indicate NONE) _____ Area Code _____ Home Telephone _____ Unlisted

License Number _____ Type of License _____ Social Security Number _____

Mailing Address _____ City _____ State _____ Zip Code _____

I hereby authorize the state where I last held a license used to practice to furnish the information requested below. The state is: _____

Current State

I also authorize my contact information to be updated. YES NO

Signature of Applicant _____ Date Signed (MM/DD/YYYY) _____

SECTION II

To be completed by Board Officials. Please mail the completed verification in a secure envelope directly to the Oregon State Board of Nursing.

License Number: _____ License Original Issue Date: _____

Applicant licensed by: Exam Endorsement Waiver Equivalency

Status of license: Current Expired Expiration Date: _____

Is license encumbered in any way? YES NO If YES, please explain on the back

Revoked Suspended Surrendered Restricted Probation

Board Seal

I hereby certify that the above is true and correct as recorded in the files of this office.

Signature: _____

Title: _____

State

Date