



Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road • Portland, OR 97224-7012
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Authority to Dispense Self-Assessment Test

Please print and forward to the OSBN with Authority to Dispense Application

Applicant Name: _____

Social Security Number: _____ CNS or NP License # : _____

Date Test Completed: _____

Instructions:

All materials received in your dispensing packet may be used to answer the following questions. Correct answers are drawn from these materials, and reflect a survey of state and federal regulation, as well as best-practice recommendations. Please choose the one best correct answer.

Multiple Choice (Fill in the circle for the one, best answer):

| | |
|---|--|
| 1. The Institute for Safe Medication Practices (ISMP) lists several error-prone abbreviations. How should a prescription reflect the instruction to take it nightly at bedtime? | <input type="radio"/> A. qhs <input type="radio"/> B. qd (EVES) <input type="radio"/> C. hs <input type="radio"/> D. write out "use nightly" |
| 2. In the <i>Prescriptive Authority in Oregon</i> booklet, which drug listed below is <u>exempt</u> from the child resistant packaging law? | <input type="radio"/> A. Steroid dose packs <input type="radio"/> B. Prenatal Vitamins <input type="radio"/> C. Aspirin <input type="radio"/> D. Amoxicillin |
| 3. Which of the following is <u>not</u> a requirement for prescription labeling, in accordance with Oregon State Pharmacy regulations OAR 855-043-0001 (Non-Pharmacy Dispensing Outlets)? | <input type="radio"/> A. Date <input type="radio"/> B. Address of the Patient <input type="radio"/> C. Name of the Practitioner <input type="radio"/> D. Directions for use |
| 4. According to OAR 855-041-0065 and the <i>Prescriptive Authority in Oregon</i> booklet, if a non-controlled substance medication is ordered "prn" and a defined number of refills are written, it may be refilled for : | <input type="radio"/> A. 6 months <input type="radio"/> B. 3 refills <input type="radio"/> C. 2 years <input type="radio"/> D. Until the prescriber authorizes it to be changed |
| 5. The following medications may <u>not</u> be refilled without a new handwritten prescription : | <input type="radio"/> A. "Morning After Pill" <input type="radio"/> B. Insulin <input type="radio"/> C. Methylphenidate <input type="radio"/> D. Xolair |
| 6. Drug dispensing records must be kept by the practitioner for a minimum of : | <input type="radio"/> A. 1 year <input type="radio"/> B. 6 months <input type="radio"/> C. 3 years <input type="radio"/> D. 7 years |

| | |
|--|---|
| 7. According to <i>Poison Prevention Packaging: A Text for Pharmacists and Physicians</i> , which medication is required to be packaged in child resistant packaging? | <input type="radio"/> A. Ibuprofen (>200mg dosage) <input type="radio"/> B. Lidocaine (if >5mg per package) <input type="radio"/> C. Oral Contraceptives <input type="radio"/> D. Vitamin K |
| 8. According to the <i>Prescriptive Authority in Oregon</i> booklet, which medication may be dispensed or prescribed by a Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) for <u>pain management only</u> ? | <input type="radio"/> A. Codeine <input type="radio"/> B. Darvon <input type="radio"/> C. Methadone <input type="radio"/> D. Propoxyphene N-100 |
| 9. According to the ISMP, which of the following is a common drug name abbreviation that can result in error? | <input type="radio"/> A. T3 <input type="radio"/> B. STMP <input type="radio"/> C. HPV <input type="radio"/> D. K+ |
| 10. Which of the following elements make up a state defined "tamper proof" prescription? | <input type="radio"/> A. Sequential numbering <input type="radio"/> B. Heat sensitive ink <input type="radio"/> C. Watermark which can't be copied <input type="radio"/> D. All of the above |

True/ False (Fill in the circle for the correct answer)

True False

| | True | False |
|---|-----------------------|-----------------------|
| 11. Medications dispensed by a Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) must be prepackaged by a pharmacist or a manufacturer registered with the Oregon State Board of Pharmacy. | <input type="radio"/> | <input type="radio"/> |
| 12. Under federal DEA regulations as stated in the <i>Pharmacist's Manual 2001</i> , a biennial inventory must be taken of all controlled substances on hand and available for dispensing. | <input type="radio"/> | <input type="radio"/> |
| 13. According to OAR 851-056-0024 (2)(b), labels must include a physical description of all medications dispensed. | <input type="radio"/> | <input type="radio"/> |
| 14. According to OAR 855-043-0001, all drugs dispensed must contain an expiration date. | <input type="radio"/> | <input type="radio"/> |
| 15. Under the Poison Prevention Packaging Act (PPPA) a patient must have <u>all</u> medications dispensed in child proof packaging. | <input type="radio"/> | <input type="radio"/> |
| 16. The ISMP preferred abbreviation for magnesium sulfate is Mg S04. | <input type="radio"/> | <input type="radio"/> |
| 17. A Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) may dispense buprenorphine for narcotic addiction on an outpatient basis. | <input type="radio"/> | <input type="radio"/> |
| 18. A Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) in Oregon may dispense medications for assisted suicide, if at least two physicians have certified the patient. | <input type="radio"/> | <input type="radio"/> |
| 19. Registration with the DEA (Drug Enforcement Administration) is required to prescribe, procure, distribute, or dispense Schedule II-V drugs. | <input type="radio"/> | <input type="radio"/> |
| 20. A Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) may delegate certain non-judgemental dispensing functions to a RN or medical assistant. | <input type="radio"/> | <input type="radio"/> |

I verify that I have reviewed the correct answers and reference materials cited in this self-assessment.

Printed Name: _____

Signature: _____ Date: _____

Send completed test and Authority to Dispense application to :

Oregon State Board of Nursing, 17938 SW Upper Boones Ferry Road, Portland, Oregon, 97224-7012
Attention: Advanced Practice Consultant



Oregon State Board of Nursing
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Please use a black pen or pencil. Avoid "gel" pens, as they bleed through paper.

Authority to Dispense Prescription Drugs Application

For office use only

FEE OWED FOR THIS APPLICATION:

\$ 0.00

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

SECTION 1: LICENSE TYPE

Which license do you currently hold with Prescriptive Authority? [] CNS [] NP

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 authority to dispense prescription drugs 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: REQUEST FOR AUTHORITY TO DISPENSE PRESCRIPTION DRUGS

Please check the following boxes, as appropriate.

I have reviewed each of the following materials:

1. Prescriptive Authority in Oregon for Nurse Practitioners and Clinical Nurse Specialists. (OSBN Publication)
2. Pharmacist's Manual (DEA Publication).
3. Oregon Administrative Rule 851-056
4. Oregon Administrative Rule 855 (provided selections).
5. Oregon Revised Statute Chapter 689 (provided selections) and ORS Chapter 855.
6. Poison Prevention Packaging: A Text for Pharmacists and Physicians (US Consumer Product Safety Commission publication).
7. List of Error-Prone Abbreviations, Symbols and Dose Designations (The Institute for Safe Medication Practices publication).
8. Oregon State Board of Pharmacy list of manufacturers registered in Oregon.

I affirm that access to pharmacy services is not readily available, as evidenced by the following. (Check all that apply.)

1. The patient lives outside boundaries of a metropolitan statistical area (as defined by the federal Office of Management and Budget).
2. The patient lives 30 or more highway miles from the closest hospital within the major population center in a metropolitan statistical area (as defined by the federal Office of Management and Budget).
3. The patient lives in a county with a population of less than 75,000.
4. The patient receives services from a health safety net program.
5. The patient participates in a patient assistance program of a pharmaceutical company.
6. The patient is seen at a qualified institution of higher learning (i.e. - college health center).
- I affirm that granting me the authority to dispense prescription drugs would correct this lack of access.

I have a plan to obtain DEA certification to dispense.

- No Yes. I verify that I am in compliance with federal and state regulations regarding the storage, inventory and distribution of controlled substances.
- I verify I have completed the Dispensing Authority Self-Assessment Test and have reviewed the correct answers.
- I verify I have at my dispensing site the hard copy or electronic version of _____ prescription drug reference.

SECTION 6: 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.)