



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.)