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 Prescriptive Privilege

Use this application if:

You are an Oregon licensed NP/CNS/CRNA advanced practice nurse applying to add prescriptive privilege to your existing license.

What to do after you fill out the application:

1. **Mail us your application & fees**: **All OSBN fees are non-refundable, even if you don't finish your application.** Submit the original signed application, as copies are not accepted. Mail application and your personal check or money order to OSBN at: 17938 SW Upper Boones Ferry Rd, Portland OR 97224.
2. **Complete your background check**: **OSBN requires a national fingerprint-based criminal background check** to apply for and be issued a license. Criminal background checks completed by employers, other agencies, or other state/US jurisdictions are not accepted. Electronic fingerprinting services are provided by Fieldprint Inc, an independent contractor with the State of Oregon.
3. **Check your email:** Once your application and full payment are received, you will be sent an email (check your inbox and junk mail) to the address you provided on your application. It gives you the instructions you need in order to register online with Fieldprint Inc to schedule and pay for your fingerprinting appointment.
4. **Fingerprinting Fee:** In order to schedule a fingerprinting appointment, Fieldprint Inc charges a separate $64.50 service fee. **This fee is collected during Fieldprint's online registration process.**
5. **Check your application status**: You may track the progress of your application using the Application Status Wizard available on the OSBN website at: www.oregon.gov/OSBN.

Non-refundable application fee: $75

Application Eligibility

Per OAR 851-053-0005(3), an applicant for prescriptive privilege must show:

(a) Completion of initial education program within two years prior to the application date providing at least 45 contact hours of advanced pharmacology concepts; or

(b) Evidence of completion of a 30-hour discrete pharmacology course congruent with the specialty role sought and an additional 15 contact hours in pharmacological management congruent with the licensure being sought and population foci for a total of 45 contact hours; or

(c) Current prescriptive privilege in another state or U.S. jurisdiction, including a U.S. federal institution or facility; or

(d) Evidence of successful completion of required clinical education in pharmacological management. An applicant may be considered to meet this requirement through:

- (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 role sought; or
- (B) Evidence of unencumbered prescriptive privilege in another state or U.S. jurisdiction, including a U.S. federal institution or facility with a minimum of 150 hours utilizing applied pharmacological management of patients congruent with their specialty role within the previous two years; or
- (C) Validation of prescribing competencies by a licensed independent prescribing practitioner (NP, CNS, CRNA, MD, DO) that demonstrates 150 hours of the applicant's knowledge and application of pharmacological management of patients congruent with their specialty role. Applicants must complete the OSBN APRN Pharmacological Management Evaluation Form.

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

OSBN USE ONLY- Application Expiration Date

OSBN USE ONLY- Additional Information
□ Qualifications Met
□ State License Verified
□ Background Check

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Mail original signed application and check or money order to: OSBN 17938 SW Upper Boones Ferry Rd, Portland, OR 97224.

Application Fee: $75 OR APRN License Number: _____

Section 1: Applicant Name and Contact Information

Last Name:		First Name:	
Middle Name:		Former Name(s):	
Address:		Country: United States	
City:		State:	Zip:
Primary Phone:		Email: (required)	

NOTE: OSBN uses the email address on file for all application and licensing renewal notifications. It is your responsibility to keep information on file current with OSBN to ensure receipt.

Section 2: Applicant Personal Identifiers

Gender: Female ☐ Male ☐ Other/Non-Binary ☐

Date of Birth: ____ ____ ____

Section 4: Eligibility

Check the box next to the statement that corresponds to how you qualify for prescriptive privilege. If you check (d), you must also check the secondary box for (A), (B), or (C).

☐ (a) Completion of initial education program within two years prior to the application date providing at least 45 contact hours of advanced pharmacology concepts; **or**

☐ (b) Evidence of completion of a 30-hour discrete pharmacology course congruent with the specialty role sought and an additional 15 contact hours in pharmacological management congruent with the licensure being sought and population foci for a total of 45 contact hours; **or**

☐ (c) Current prescriptive privilege in another state or U.S. jurisdiction, including a U.S. federal institution or facility; **or**

☐ (d) Evidence of successful completion of required clinical education in pharmacological management. An applicant may be considered to meet this requirement through:

- ◯ (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 role sought; or
- ◯ (B) Evidence of unencumbered prescriptive privilege in another state or U.S. jurisdiction, including a U.S. federal institution or facility with a minimum of 150 hours utilizing applied pharmacological management of patients congruent with their specialty role within the previous two years; or
- ◯ (C) Validation of prescribing competencies by a licensed independent prescribing practitioner (NP, CNS, CRNA, MD, DO) that demonstrates 150 hours of the applicant's knowledge and application of pharmacological management of patients congruent with their specialty role. Applicants must complete the OSBN APRN Pharmacological Management Evaluation For

Section 5: Background Information

Read each question carefully and select a NO or YES answer. Any false, misleading, or incomplete information is considered falsifying an application and is grounds for denial of your application or discipline on your license/certification.

Question 1: Use of Alcohol or Drugs

For Question 1(a) & (b) & (c):
If you answer YES, describe your alcohol/drug use history and details of any treatment you have undergone with relevant dates. Provide any available documentation of your sobriety (e.g. letters, program records, or certificates of completion), if applicable.

You may answer NO if you are currently enrolled in Oregon's Health Professionals Services Program (HPSP) as a **Self-Referral**. *Self-referral* means that you have independently and voluntarily enrolled in HPSP, and are being monitored. If you have had a Board investigation that resulted in your enrollment, you must answer YES.

Question 1 (a): a. In the last two years, have you used alcohol or any drugs in a way that could impair your ability to practice nursing or perform nursing assistant duties with reasonable skill and safety?	◯ **YES**	◯ **NO**
Question 1 (b): b. In the last two years, have you been diagnosed with or treated for a substance use disorder? If yes, include your sobriety date in your explanation.	◯ **YES**	◯ **NO**
Question 1 (c): c. In the last two years, have you used any illegal drugs or prescription drugs in a manner other than prescribed?	◯ **YES**	◯ **NO**
Question 1 (d): If you answer YES, provide a detailed explanation with relative dates, surrounding circumstances, and state or jurisdiction where monitored. Include any supporting documentation with your application. d. Are you currently in an impaired monitoring program in another U.S. state or jurisdiction including an alternative-to-discipline program?	◯ **YES**	◯ **NO**

Question 2: Ability to Practice Nursing Safely

If you answer YES, describe your condition, its effects, and how you manage the condition.

Question 2(a): a. Do you currently have a physical condition that impacts your ability to practice nursing, or perform nursing assistant duties with reasonable skill and safety? If you are currently not practicing due to this condition i.e. medical leave, disability, etc. you may answer "no".	◯ **YES**	◯ **NO**
Question 2(b): b. Have you been diagnosed with a mental or emotional condition that is currently impacting your ability to practice nursing or perform nursing assistant duties with reasonable skill and safety? If your condition is currently stabilized through medical intervention and/or therapy, you may answer "no".	◯ **YES**	◯ **NO**

Question 3: Background

If you answer YES, describe the incidents and the surrounding circumstances. Include relevant dates, the city and state where the incidents occurred, and the outcome of any criminal charges. Provide copies of court documentation that identifies the charges and final adjudication.

Have you ever pled guilty, been convicted of, pled No Contest for, or entered into an Alford plea for a felony or misdemeanor? **ATTENTION**: You may answer NO for juvenile convictions that were expunged or "set aside", or adult convictions that were "set aside". If you are currently enrolled in a diversion program for DUII you may answer NO unless you pled guilty – then you must answer YES.	◯ **YES**	◯ **NO**

Applicant Last Name:	**First Name:**

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Question 4: Abuse or Mistreatment		
If you answer YES, provide a detailed explanation that includes the name of the agency that conducted the investigation. Provide documentation of the outcome of the investigation and any investigative reports.		
Have you ever had a case substantiated or founded against you for abuse, neglect, or mistreatment, by any state or jurisdictional authority?	◉ YES	○ NO
Question 5: Healthcare Violations		
If you answer YES, provide a detailed explanation of the incident that led to the discipline. Provide documentation of the Board order.		
Has your healthcare license or certificate ever been revoked, voluntarily surrendered, suspended or otherwise disciplined by any regulatory Board in any state or jurisdiction for violation of state or federal law, rule, or practice standard? **ATTENTION**: This includes if you have stipulated to an agreement for withdrawal of an application, or the denial of licensure/certification.	○ YES	○ NO
Question 6: Withdrawal of Federal Practice Ability		
If you answer YES, provide a detailed explanation of the allegations and subsequent investigation. Provide documentation of the final determination.		
Have you ever had your ability to practice in a federally qualified insurance program, such as Medicare and Medicaid, withdrawn through placement on the Certified Nurse Assistant Abuse Registry, the National Practitioner Databank, or the Inspector General Exclusion List? **ATTENTION**: You must answer yes even if your privileges have been reinstated after being withdrawn.	○ YES	○ NO
Question 7: Malpractice		
If you answer YES, describe the incidents that led to the action for notice or civil judgement against you. Provide documentation of the final determination.		
Have you ever had a notice of civil judgement awarded against you for malpractice, negligence, or incompetence related to your nursing license or nursing assistant certificate? **ATTENTION**: This includes lawsuits that you are named in where a monetary settlement was reached regardless of admission of guilt.	○ YES	○ NO

Section 6: Practice Location

Indicate below the primary location in Oregon that you will be utilizing your prescriptive privileges at.

Business Name:		Telephone:	
Site Address:	City:	State:	Zip:

Section 7: Authorization Statement

LIC-204 ***Application for APRN Prescriptive Privilege***

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/yy)