

APPLICATION FOR AUTHORIZATION TO PRESCRIBE

SECTION 1: TO BE COMPLETED BY THE RN

NAME (PRINT)		REGISTRATION NUMBER
EMAIL	PHONE	
PRESCRIBING PROGRAM/SCHOOL		COMPLETION DATE

VERIFICATION AND NURSE SIGNATURE

1. I CONFIRM THAT I HAVE THE NECESSARY COMPETENCE, CHARACTER, AND CONDUCT TO PRESCRIBE SAFELY AND ETHICALLY.	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. I ACKNOWLEDGE THAT MY AUTHORITY TO PRESCRIBE IS SPECIFIC AND LIMITED TO THE CLIENT CONDITIONS AND PRACTICE SETTINGS AS IDENTIFIED BY MY EMPLOYER AND DEFINED THROUGH THEIR POLICIES, GUIDELINES, OR OTHER DECISION SUPPORT TOOLS.	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. I ACKNOWLEDGE THAT I AM REQUIRED TO NOTIFY NSCN WHEN I LEAVE (PERMANENTLY OR FOR AN EXTENDED PERIOD) MY APPROVED PRACTICE SETTING TO WORK IN A SETTING WHERE PRESCRIBING IS NOT OR NO LONGER REQUIRED.	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. I HAVE REVIEWED THE RN PRESCRIBER STANDARDS OF PRACTICE, RN PRESCRIBER COMPETENCIES, RN PRESCRIBER SCOPE OF PRACTICE, AND THE RN PRESCRIBER PRACTICE GUIDELINES.	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. I ACKNOWLEDGE THAT INFORMATION ABOUT MY AUTHORIZATION TO PRESCRIBE WILL BE PUBLICLY AVAILABLE IN THE SEARCH A NURSE FUNCTION OF THE NSCN WEBSITE AND SHARED WITH THE DEPARTMENT OF HEALTH AND WELLNESS / DRUG INFORMATION SYSTEM (DIS) AND MEDAVIE BLUE CROSS.	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. I CONSENT TO NSCN VERIFYING ANY AND ALL INFORMATION, WHICH MAY INCLUDE CONTACTING EMPLOYERS, INSTITUTIONS OR AUTHORITIES CITED IN MY APPLICATION.	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. I UNDERSTAND THAT ANY AND ALL INFORMATION PROVIDED TO NSCN IN THE COURSE OF THE APPLICATION PROCESS MAY BE USED INTERNALLY BY NSCN IN ANY OF ITS REGULATORY FUNCTIONS.	YES <input type="checkbox"/> NO <input type="checkbox"/>
8. I ACKNOWLEDGE THE ANSWERS I PROVIDED ON THE MOST RECENT APPLICATION TO RENEW MY RN REGISTRATION AND LICENSE HAVE NOT CHANGED.	YES <input type="checkbox"/> NO <input type="checkbox"/>
9. I ATTEST THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND ACCURATE.	YES <input type="checkbox"/> NO <input type="checkbox"/>

RN SIGNATURE	DATE
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RN NAME (PRINT)	REGISTRATION NUMBER

SECTION 2: TO BE COMPLETED BY THE EMPLOYER

NAME (PRINT)	TITLE
ORGANIZATION/SITE	
EMAIL	PHONE

CLIENT CONDITIONS AND PRACTICE SETTINGS

Complete the section below **or** attach a typed list of conditions and practice settings

I REQUEST THIS NURSE BE AUTHORIZED TO PRESCRIBE FOR THE FOLLOWING CONDITIONS:			

I REQUEST THIS NURSE BE AUTHORIZED TO PRESCRIBE IN THE FOLLOWING PRACTICE SETTINGS:	

APPLICATION FOR AUTHORIZATION TO PRESCRIBE

RN NAME (PRINT)	REGISTRATION NUMBER

ABOUT RN PRESCRIBER PRACTICE SETTING

THE NURSE NAMED ABOVE IS IN A ROLE WHERE RN PRESCRIBING IS REQUIRED.	YES <input type="checkbox"/> NO <input type="checkbox"/>
ARE THERE ANY EMPLOYER CONDITIONS, RESTRICTIONS, OR LIMITATIONS ON THE RN PRESCRIBERS PRACTICE?	YES <input type="checkbox"/> NO <input type="checkbox"/>
IF YES, PLEASE DESCRIBE:	
RESOURCES REFLECTING THE RN PRESCRIBER STANDARDS OF PRACTICE AND COMPETENCIES, INCLUDING BUT NOT LIMITED TO DECISION SUPPORT TOOLS, POLICIES, GUIDELINES, REFERENCES, MENTORS, ETC. ARE IN PLACE TO SUPPORT SAFE AND COMPETENT RN PRESCRIBER PRACTICE.	YES <input type="checkbox"/> NO <input type="checkbox"/>
THERE IS AN ESTABLISHED PROCESS TO ENABLE COLLABORATION BETWEEN THE RN PRESCRIBER AND AN APPROPRIATE HEALTH CARE PROVIDER, SUCH AS NP OR PHYSICIAN.	YES <input type="checkbox"/> NO <input type="checkbox"/>
I ACKNOWLEDGE THAT THE RN PRESCRIBER'S AUTHORITY TO PRESCRIBE IS SPECIFIC AND LIMITED TO THE CLIENT CONDITIONS AND PRACTICE SETTINGS AS IDENTIFIED BY THE EMPLOYER RESOURCES, POLICIES, GUIDELINES, AND/OR OTHER DECISION SUPPORT TOOLS.	YES <input type="checkbox"/> NO <input type="checkbox"/>

EMPLOYER SIGNATURE	DATE

