OKLAHOMA Board of Nursing | OKLAHOMA State Board of Medical Licensure and Supervision | OKLAHOMA State Board of Osteopathic Examiners

Agreement for Physician Supervising Advanced Practice Registered Nurse Prescriptive Authority

Advanced Practice Registered Nurses: APRNs

Use this document for the following:

1. Complete and upload to your Nurse Portal account for each current Supervising Physician **when renewing prescriptive authority every two years (during your 90-day renewal period).**

2. Complete and upload **when adding or deleting supervising physician(s) for previously granted prescriptive authority.** ***Note:*** Must be submitted within thirty (30) days of the addition or deletion.
   TWO STEP PROCESS:
   a. When adding a supervising physician, submit the *"Request for Change in Physician(s) Supervising Advanced Practice Authority (for the CNP, CNM, and CNS)"* as found in the Other Applications link through your Nurse Portal account and submit the required fee.
   b. Next, upload a completed "Agreement for Physician Supervising Advanced Practice Registered Nurse Prescriptive Authority" form.

3. Complete and upload Agreement(s) for all requested supervising physician(s) when submitting your application through your Nurse Portal account **for initial or endorsed-in prescriptive authority recognition.**

4. Complete and upload Agreement(s) for all supervising physicians during the submission of your application **for Reinstatement of Prescriptive Authority recognition** as found in your Nurse Portal account.

Complete Part I, distribute to your supervising physician for their completion of Parts II and III, including the physician's signature on page 3 of the Agreement. ***Note:*** *The APRN must sign the Attestation on Page 3 of the physician-completed Agreement and provide a copy of the fully executed Agreement to the supervising physician.*

This *Agreement* is NOT required if the APRN is working in a Veteran's Administration (VA) facility, has submitted written verification that VA has granted full practice authority, AND is NOT prescribing Controlled Dangerous Substances (38 C.F.R. § 17.415).

This *Agreement* is NOT required if the APRN has been granted independent prescriptive authority by the Oklahoma Board of Nursing.

Medical Doctors/Physicians: M.D.s

Complete Part II, and complete and sign Part III, then return to the APRN.
The APRN must sign the Attestation on page 3 of the Agreement.
Email the completed Agreement to: licensing@okmedicalboard.org

Doctors of Osteopathy/Physicians: D.O.s

Complete Part II, and complete and sign Part III, then return to the APRN.
The APRN must sign the Attestation on page 3 of the Agreement.
Upload a copy of the completed Agreement to your Board profile. See the Oklahoma State Board of Osteopathic Examiners (OSBOE) website for additional information: Oklahoma State Board of Osteopathic Examiners (525).

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Agreement for Physician Supervising Advanced Practice Registered Nurse Prescriptive Authority

Part I: To be Completed by the Advanced Practice Registered Nurse (APRN)

1. Name (as it appears on APRN license): _____

2. OK APRN License Number: _____ Expiration Date: _____

3. Role of APRN held in OK (Check one) ☐ CNP ☐ CNS ☐ CNM

4. Specialty (population focus) of APRN license/role held in OK (ex: Family; Neonatal) for which you are requesting this supervising physician to be added:

_____

5. **Purpose for Submission** of *Agreement for Physician Supervising Advanced Practice Registered Nurse Prescriptive Authority* (*check one*):

☐ **Addition of a physician for previously granted prescriptive authority** (upload the *Agreement* during submission of the *Change of Supervising Physician* form and fee as found in your Nurse Portal account)

☐ **Application for prescriptive authority** (upload the *Agreement* during submission of your application via your Nurse Portal account)

☐ **Renewal of prescriptive authority** (upload the *Agreement* after completing the renewal in your Nurse Portal account)

☐ **Reinstatement of prescriptive authority** (upload the *Agreement* during submission of the reinstatement application and its associated fee via your Nurse Portal account)

Part II: To be Completed by the Physician (M.D. and D.O.)

1. Physician Name (please print/type):

_____ _____ _____
First Name Middle/Initial Last Name

2. Physician Type: (check one): ☐ M.D. ☐ D.O.

3. OK License Number: _____ Expiration Date: _____

Questions 4. through 8. are required by M.D. and D.O. Boards.

4. Physician's Contact Information: _____
Telephone Number(s)

_____ _____ _____ _____
Street Address City State Zip Code

5. Practice Specialty: _____

National Board Certification: _____ ☐ None
(Check if none)
Uncheck

6. Do you have an **unrestricted** license from the Oklahoma State Board of Medical Licensure and Supervision or from the Oklahoma State Board of Osteopathic Examiners?

   ☐ Yes ☐ No

7. Oklahoma Bureau of Narcotics and Dangerous Drugs Control (OBNDD):

   A. Do you have a **current** permit from the OBNDD? ☐ Yes ☐ No

   B. Do you have an **unrestricted** permit from the OBNDD? ☐ Yes ☐ No*

   *If No, please describe the restriction(s): _____

   _____

8. Drug Enforcement Administration (DEA):

   A. Do you have a **current** permit from the DEA? ☐ Yes ☐ No

   B. Do you have an **unrestricted** permit from the DEA? ☐ Yes ☐ No*

   *If No, please describe the restriction(s): _____

   _____

Part III: Prescriptive Authority Supervision

APRN Name: _____

APRN License Number: _____

Supervising Physician Name: _____

Physician License Number: _____ ☐ Primary Physician ☐ Alternate Physician

METHOD(S) OF SUPERVISION AND COLLABORATION

1. **Plan for review/conference regarding prescriptive authority:** Reset
   (check all that apply)

☐ Face-to-face ☐ Virtual discussions ☐ Chart reviews ☐ Joint Rounding

☐ Conference calls ☐ Performance evaluations ☐ Other (Describe)_____

2. **Frequency of review meetings/conferences*:** Reset
   (check all that apply)

☐ Daily in Person ☐ Weekly in Person ☐ Daily Via Telecommunication

☐ Weekly Via Telecommunication ☐ Other (Describe):_____

*The supervising physician must have continuous availability of direct communications either in person or by electronic communications with the Advanced Practice Registered Nurse.

3. **APRN prescriptive authority:** All APRNs are able to prescribe medical supplies, non-scheduled medications, and Schedule III–V Controlled Dangerous Substances subject to the Exclusionary Formulary for Advanced Practice Registered Nurses with Prescriptive Authority. The APRN must have separate prescriptive authority for each certification/population focus.

4. **Fees charged to the APRN for supervision services:** _____

5. **Procedures for notice to the APRN for periods of absence:**

   Method of notice: _____ Time frame for notice:_____

6. **Alternate physician(s) for periods of Primary Physician absence*:**_____

_____

*APRNs must submit a *Request for Change in Physician(s) Supervising Advanced Practice Registered Nurse Prescriptive Authority (for the CNP, CNM, and CNS)* to add or delete a supervising physician, with a completed *Agreement for Physician Supervising Advanced Practice Registered Nurse Prescriptive Authority,* to the Oklahoma Board of Nursing within thirty (30) days of the addition/deletion for all supervising physicians, including alternates.

SUPERVISING PHYSICIAN'S ATTESTATION

Supervision of Advanced Practice Registered Nurses with prescriptive authority means overseeing and accepting responsibility for the ordering and transmission of written, telephonic, electronic or oral prescriptions for drugs and other medical supplies, subject to a defined formulary [O.S. 567.3a(11) and (12)].

I, _____ agree to supervise the prescriptive authority practice of
Print Name of supervising physician

_____ effective _____.
Print Name of Advanced Practice Registered Nurse Date

I further agree to be available for consultation, collaboration, assistance with medical emergencies, and patient referral through direct contact, telecommunications or other appropriate electronic means. I am not in training as an intern, resident or fellow. I have reviewed the Exclusionary Formulary approved by the Oklahoma Board of Nursing. I agree to remain in compliance with the Rules and Regulations promulgated by the Oklahoma State Board of Medical Licensure and Supervision (for M.D.s) or Oklahoma State Board of Osteopathic Examiners (for D.O.s). I attest that this supervision Agreement complies with 59 O.S. § 479.1. Further, I certify that the statements contained in this Agreement are true and correct.

Signature of Physician: _____ ☐ M.D. ☐ D.O. (check one)

ADVANCED PRACTICE REGISTERED NURSE'S ATTESTATION

I attest that I have reviewed the physician-completed sections of this Agreement, the information contained in this Agreement is true and correct, and the terms of this Agreement with the above supervising physician regarding supervision of my prescriptive authority are accurate.

Signature of APRN: _____ Date: _____