IDAHO BOARD OF NURSING
Mailing: PO Box 83720 - Boise, Idaho 83720-0061
(208) 334-3110

Instructions for Application
for
Prescriptive and Dispensing Authorization

I. Complete the application on the reverse side of these instructions and have the Affidavit notarized.

II. Submit evidence of completion of thirty (30) hours of post-basic education in pharmacotherapeutics by submitting a copy of a transcript, course work, letter from program or presenter or certificate of completion. The education must have been obtained as part of study within a formal education program or continuing education program, which are related to the applicant's advanced practice category scope of practice

III. Request the educational program to complete and return <u>directly to the Board of Nursing</u> the enclosed check-list indicating instruction in the following :

(1) Pharmacokinetic principles and their clinical application;
(2) The use of pharmacologic agents in the prevention of illness, restoration and maintenance of health;
(3) Federal and state laws relating to the purchasing, possessing, prescribing, administering and disposing of pharmacologic and nonpharmacologic agents;
(4) Prescription writing;
(5) Drug selection, dosage and route of administration; and
(6) Drug interactions.

IV. Submit a non-refundable fee of fifty dollars ($50) - personal checks are acceptable.

V. Qualified advanced practice professional nurses may be authorized to prescribe and dispense legend drugs and Schedule II to V controlled substances. Applicants seeking controlled substance registration should contact the Idaho Board of Pharmacy, PO Box 83720, Boise, Idaho 83720-0067, (208) 334-2356 or download the appropriate application at:
www.state.id.us/bop/forms/index.html (CS)
www.deadiversion.usdoj.gov/drugreg/index.html (DEA) .

IDAHO BOARD OF NURSING - PO BOX 83720 - BOISE, ID 83720-0061
(208) 334-3110

License #______________
Receipt #______________
Amount______________

Authorization

Temp______________

Continuing______________

APPLICATION FOR PRESCRIPTIVE AND DISPENSING AUTHORIZATION

Check category of licensure:

- ☐ Certified Nurse-Midwife
- ☐ Clinical Nurse Specialist
- ☐ Nurse Practitioner
- ☐ Registered Nurse Anesthetist

Name____
Last First Middle Maiden

Other names used previously______________________________

Mailing Address____________________________________
City State Zip Code

Home Telephone Number ( )______________ Work Telephone Number ( )______________

Social Security Number______________ APPN NUMBER______________

EDUCATION *

Name of Program of Study for Pharmacotherapeutics:

____

Location of Program:______________________________

Dates Attended:______________________________

*Submit evidence of completion of thirty (30) contact hours of post-basic education in pharmacotherapeutics

THE AFFIDAVIT BELOW MUST BE COMPLETED IN ORDER FOR YOUR APPLICATION TO BE VALID.

AFFIDAVIT

State of ____________________)
) s.s.
County of ___________________)

I,________________________being duly sworn, declare that I have no mental or physical disabilities (except as noted above) that would preclude me from giving safe nursing care at all times; that I am the person referred to in the foregoing application; that the information supplied therein is true to the best of my knowledge; and that I have read and understand this affidavit.

____
Signature of Applicant

On this ________ day of ________________, in the year of ____________________before me __________________, notary public, personally appeared ____________________ known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

WITNESS my hand and official seal.

____
My Commission expires____________________

YOU MAY NOT PRACTICE NURSING IN IDAHO AS DEFINED IN THE NURSING PRACTICE ACT, IDAHO CODE, SECTION 54-1401 THROUGH 54-1417, UNTIL YOU HAVE FILED AN APPLICATION AND RECEIVED A TEMPORARY OR RENEWABLE LICENSE.

VERIFICATION OF PHARMACOLOGY
COURSE CONTENT AND CONTACT HOURS

LICENSURE APPLICANT

Complete the release information at the top of this form and send to the faculty of your advanced practice professional nurse education program for completion of the bottom section. *The form must be returned to our office directly from the faculty.*

YOUR NAME:____

SOCIAL SECURITY #:____________________________________

I hereby authorize you to release to the Idaho Board of Nursing for licensure purposes, the information requested below.

DATE ____________________ SIGNATURE ________________________

APPLICANT: Send this form to your faculty for completion of the bottom section.

ATTENTION: THIS FORM WILL NOT BE ACCEPTED DIRECTLY FROM THE APPLICANT.

NURSING FACULTY

The above named person has applied for licensure as an advanced practice professional nurse with prescriptive authority in the State of Idaho. Please furnish the information requested below and return the completed form by mail or FAX to:

IDAHO BOARD OF NURSING, P.O. BOX 83720, BOISE, ID 83720-0061 (FAX: 208/334-3262)
(If sending the form by FAX, please DO NOT follow up with a hard copy. Thank you.)

I verify that the individual listed above completed the following number of contact hours in pharmacology: ☐

The contact hours were obtained in the following advanced practice nursing courses (list course names and numbers):

____

____

____

The courses included the following pharmacology content:

- ☐ Pharmacokinetic principles and their clinical application;
- ☐ The use of pharmacologic agents in the prevention of illness, restoration and maintenance of health;
- ☐ Federal and state laws relating to the purchasing, possessing, prescribing, administering and disposing of pharmacologic and non-pharmacologic agents;
- ☐ Prescription writing;
- ☐ Drug selection, dosage and route of administration; and
- ☐ Drug interactions

NAME AND ADDRESS OF NURSING EDUCATION PROGRAM:

____

____

____

FAX AND PHONE NUMBERS: __________________________________

DATE ____________________ FACULTY SIGNATURE AND TITLE ________________________

7/98
5/06