

**APPLICATION FOR APPN LICENSURE  
HOLDS COMPACT RN LICENSE**

**Use this application if:**

**The applicant lives in a Compact State**

**An Idaho APPN license has never been issued previously**

**Application for Prescriptive and Dispensing Authorization for Prescriptive Authority - Complete this application (included) if you plan to prescribe legend drugs in the State of Idaho.**

**Criminal Background checks - All applicants are required to submit to a fingerprint-based criminal background check by the Idaho Central Criminal Database and Federal Bureau of Investigation criminal history database. Cards are available from the Board office.**

<b>Total Fees to be submitted:</b>	<b>APPN Application Fee -</b>	<b>\$90.00</b>
	<b>Fingerprint Processing Fee -</b>	<b>\$30.00</b>
	<b>Prescriptive Authorization (if needed) -</b>	<b>\$50.00</b>

## APPLICATION INSTRUCTIONS FOR ADVANCED PRACTICE PROFESSIONAL NURSES NURSE LICENSURE - COMPACT STATE RESIDENT

This application may be used by nurses applying for licensure as an advanced practice professional nurse (CNM, CNS, NP, RNA). **NOTE: If you are applying for advanced practice licensure and are currently licensed as a professional nurse (RN) and are residing in a State that has adopted the Nurse Licensure Compact, you do not need to apply for an Idaho professional nurse (RN) license in addition to your APPN license.**

The following must be on file with the Board of Nursing in order to determine your eligibility for APPN licensure in Idaho. Documents requiring notarization may NOT be received by FAX. (All documents become the property of the Board and may be destroyed, without further notification, if the application is not completed within one year.)

1. **APPLICATION FORM:** Only application forms provided by the Board, completed in ink and notarized will be accepted. Photocopies or faxed copies of application forms will not be accepted.
  - 1) If all information requested is not supplied, provide an explanation for the omission.
  - 2) Sign the affidavit with your usual signature and have it notarized.
  - 3) Attach a 2 x 2 identification photograph, taken within the last year. Electronically scanned photos are not acceptable; features must be clearly identifiable. Black & white or color photos are acceptable.
2. **FEE.** Enclose the appropriate fee:

Advanced Practice Professional Nurse (CNM, CNS, NP, RNA)	-	\$90.00
APPN Temporary License (available upon request)	-	No Fee
Fingerprint Processing Fee	-	\$30.00
3. **CENSUS QUESTIONNAIRE:** Complete the enclosed Census Questionnaire and return with your completed application.
4. **OFFICIAL TRANSCRIPT:** Request an OFFICIAL TRANSCRIPT indicating completion of an Advanced Practice Professional Nursing education program. The transcript must be mailed directly to the Board of Nursing office by the granting institution.
5. **RN LICENSE.** Attach a copy of your current RN license in a Compact state to the enclosed affidavit.
6. **ADVANCED PRACTICE PROFESSIONAL NURSE NATIONAL CERTIFICATION.** Attach a copy of your current certificate to the enclosed affidavit.
7. **DECLARATION OF STATE OF RESIDENCE.** Complete the enclosed form attesting that your primary residence is in a Compact state.
8. **FINGERPRINT CARD.** All applicants for licensure are required to submit to a fingerprint-based criminal background check by the Idaho central criminal database and the federal bureau of investigation criminal history database. Complete the required fingerprint card and submit to the Board for processing. Only cards from the Board office are acceptable - **fee for processing - \$30.00.** Cards can take from 3-4 weeks for processing.

### INSTRUCTIONS FOR TEMPORARY LICENSURE

Advanced practice professional nurse applicants (CNM, CNS, NP, RNA) applying for APPN temporary licensure, who reside in and are currently authorized to practice in a Compact state must submit the completed application form and the "Affidavit Attesting to Validity of Copy", attached item 1 or 2:

1. A copy of your current national certification certificate showing the expiration date. **NOTE:** If you have not yet taken the certification examination, submit a copy of the document, which verifies acceptance to take the examination; or
2. If your national certification has lapsed, submit a copy of your lapsed certificate. The Board will consider issuance of a conditional temporary license in order for you to meet specified practice requirements for re-entry into advanced practice professional nursing, and
3. Official transcript. If a final transcript is not yet available, submission of one of the following documents is acceptable:
  - a. Correspondence received directly (by FAX or mail) from the administrator of the educational program attesting to completion of all graduation requirements; or
  - b. Notarized copy of diploma.

**PLEASE BE ADVISED:** Advanced Practice Professional Nurses must renew their license(s) by August 31<sup>st</sup> of every odd-numbered year. A nurse who applies for licensure on or after March 1<sup>st</sup> of the year, in which the license would ordinarily be renewed, will be issued a license valid until the next renewal period.

APPLICATION FOR NURSE LICENSURE

For Office Use Only

License # \_\_\_\_\_
APPN # \_\_\_\_\_
Receipt# \_\_\_\_\_
Amount \_\_\_\_\_
Approval
Temp \_\_\_\_\_
Licensure \_\_\_\_\_

Check all categories for which application is being made:

- Licensed Practical Nurse (LPN)
Licensed Professional Nurse (RN)
Advanced Practice Professional Nurse
Temporary Licensure

AFFIX A 2" X 2" PHOTOGRAPH
HEAD AND SHOULDERS ONLY
Taken within the Year
DO NOT STAPLE

Date of photo \_\_\_\_\_

Name Last First Middle Maiden

Other names used previously \_\_\_\_\_

Mailing Address \_\_\_\_\_

Telephone - Home: ( ) Work: ( ) City State Zip Code S.S. No. \_\_\_\_\_

Birthplace (City & State) Birth Date (Mo/Day/Year) \_\_\_\_\_

BASIC RN/LPN EDUCATION

Name of Practical Nursing (LPN) Education Program \_\_\_\_\_

Location \_\_\_\_\_

Month/Day/Year Graduated \_\_\_\_\_ Type of Degree/Credential \_\_\_\_\_

Name of Professional Nursing (RN) Education Program \_\_\_\_\_

Location \_\_\_\_\_

Month/Day/Year Graduated \_\_\_\_\_ Type of Degree/Credential \_\_\_\_\_

LICENSURE

- 1. Have you ever taken the State Board Test Pool Examination (SBTPE) or National Council Licensure Examination (NCLEX) in any state of the United States?
2. Have you ever been licensed or made application for licensure as an RN/LPN/APPN in Idaho prior to this date?
3. State and year of original RN/LPN licensure License No.
4. List all states in which you are or have ever been licensed

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.

**EMPLOYMENT INFORMATION**

*LIST LAST THREE (3) YEARS OF NURSING EMPLOYMENT:* (Additional information may be listed on a separate sheet.)

Name & Complete Address of Employer	Position	Employment	
		From	To

If you have not been employed in nursing within the last three years, or if there are gaps in employment, indicate your **last year of nursing employment** and explain the reason. (Supervised practice and a content update may be required if you have not engaged in nursing practice during the last three years.) \_\_\_\_\_

**IT IS THE DUTY OF EACH APPLICANT TO MAKE INQUIRY OF THE INDIVIDUAL LICENSING BOARDS REGARDING THE STATUS OF LICENSURE IN THAT STATE BEFORE RESPONDING TO THE QUESTIONS BELOW.** Ignorance of license status or disciplinary information will not constitute an excuse for incorrect information. In addition, failure to disclose all licenses may result in denial of your application or other appropriate action.

**SCREENING QUESTIONS**

**PLEASE ANSWER ALL QUESTIONS (For all "yes" answers, attach a complete explanation including dates, circumstances and supporting documents if necessary.)**

1. Has your nursing license ever been disciplined in any state (e.g., revoked, suspended, placed on probation, formally reprimanded, or otherwise encumbered)? Yes No
2. Is any action pending against your nursing license in any state? Yes No
3. Have you ever had approval to practice in an advanced role denied, limited, suspended, revoked or otherwise disciplined? NA Yes No
4. Have you ever had an application for nursing license denied? Yes No
5. Have you ever been denied admission to take a nursing examination by any state? Yes No
6. Do you have, or have you been diagnosed as having, or have you been treated for having a physical or mental condition, including drug or alcohol addiction during the past five (5) years, which may impair your ability to practice nursing with reasonable skill and safety? Yes No
7. If yes, do you require special accommodations in order to practice? NA Yes No
8. Do you currently have any felony or misdemeanor charges pending against you in any jurisdiction? Yes No
9. Have you ever pled guilty, entered a plea of nolo contendere, been convicted of, or received a withheld judgment for a misdemeanor or felony in any jurisdiction? Yes No

**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 understand the instructions and terms as set forth in this application form, that I am the person referred to in the foregoing application and this affidavit, and that I have personally completed this form, and that the information given in this application is true, correct and complete. I declare that I have no mental or physical disabilities (except as otherwise noted above) that presently interfere with my ability to competently and safely practice nursing 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 \_\_\_\_\_

**The following must be completed by Advanced Practice Professional Nurses applying for licensure in the categories of Certified Nurse-Midwife, Clinical Nurse Specialist, Nurse Practitioner or Registered Nurse Anesthetist.**

**ADVANCED PRACTICE PROFESSIONAL NURSE EDUCATION \***

\* Official Transcript is required and must be mailed by the granting institution directly to the Board of Nursing.

Please  the category for which you are applying for licensure:

**Certified Nurse-Midwife:** Name of Nurse-Midwifery Program: \_\_\_\_\_  
Location of Program: \_\_\_\_\_  
Dates Attended: \_\_\_\_\_ Degree/Credential \_\_\_\_\_

**Clinical Nurse Specialist:** Name of Graduate Nursing Program: \_\_\_\_\_  
Location of Program: \_\_\_\_\_  
Dates Attended: \_\_\_\_\_ Degree/Credential \_\_\_\_\_

**Nurse Practitioner:** Name of Nurse Practitioner Program: \_\_\_\_\_  
Location of Program: \_\_\_\_\_  
Dates Attended: \_\_\_\_\_ Degree/Credential \_\_\_\_\_

**Registered Nurse Anesthetist:** Name of Nurse Anesthesia Program: \_\_\_\_\_  
Location of Program: \_\_\_\_\_  
Dates Attended: \_\_\_\_\_ Degree/Credential \_\_\_\_\_

**ADVANCED PRACTICE PROFESSIONAL NURSE CERTIFICATION**

**APPN Certification:**

Name of certifying organization: \_\_\_\_\_

Date of original certification: \_\_\_\_\_

If not yet certified, date scheduled for examination \_\_\_\_\_

A notarized copy of your current certificate, or a document which verifies acceptance to take the examination must be enclosed.

**IDAHO BOARD OF NURSING**

*Professional Nurse (RN)*  
**CENSUS QUESTIONNAIRE**

For Office Use Only

Cert # \_\_\_\_\_  
 Rec't # \_\_\_\_\_ Amt \_\_\_\_\_  
 Date Issued \_\_\_\_\_  
 Reinstatement  
 Endorsement

Please Print

NAME : \_\_\_\_\_

ADDRESS : \_\_\_\_\_

CITY & STATE : \_\_\_\_\_

Zip Code

Idaho License No.	Birth Date	Social Security No.	Gender* (Optional)	County Name	
	/ /	- -		Residence:	Employment:
Ethnicity* (Optional) <input type="checkbox"/> Caucasian(1) <input type="checkbox"/> African American/Black(2) <input type="checkbox"/> Hispanic(3) <input type="checkbox"/> Am. Indian/Alaska Native(4) <input type="checkbox"/> Asian/Pacific Islander(5) <input type="checkbox"/> Multi-Racial(6) <input type="checkbox"/> Other(99)_____					

(\*Voluntary disclosure information – response optional)

Please choose only one answer for each question, write the appropriate number in the box to the left.

<b>EMPLOYMENT STATUS</b>	1. Employed in nursing full-time	5. Not Employed/Student	9. Retired
	2. Employed in nursing part-time	6. Not Employed/Not Seeking	
	3. Employed outside nursing	7. Volunteer	
	4. Not Employed/Seeking Employment	8. Emeritus	
<b>PRIMARY EMPLOYER</b>	Employer _____ Address _____		
<b>PRIMARY EMPLOYMENT</b>	1. Hospital	7. Assisted Living	99. Other (specify) _____
	2. Nursing Home	8. Nursing Education	
	3. Home Health/Hospice	9. Insurance Company	
	4. Public Health	10. Jail/Prison	
	5. Occupational Health	11. School Health	
	6. Medical Office/Clinic	12. Outpatient Facility	
<b>TYPE OF POSITION</b>	1. Staff or General Duty	6. Quality Assurance/Outcomes Management	
	2. Case Manager/Discharge Planner	7. Consultant/Researcher	
	3. Administrator/Supervisor	8. Charge/Lead Nurse/ Team Leader	
	4. Educator	99. Other (specify) _____	
	5. Advanced Practice (not RN Specialty)		
<b>MAJOR CLINICAL AREA</b>	1. Geriatric	5. Psychiatric/Mental Health	99. Other (specify) _____
	2. Gynecologic/Obstetric	6. Emergency	
	3. Medical/Surgical	7. Community/Public Health	
	4. Pediatric	8. Rehabilitation/Restorative	
<b>BASIC EDUCATION</b>	1. Diploma	3. Baccalaureate Degree or Higher	
	2. Associate Degree	4. Other (specify) _____	
<b>HIGHEST DEGREE</b>	1. Diploma/RN	6. Masters in Other Field (specify) _____	10. PN Associate Degree
	2. Associate Degree/RN	7. Doctorate in Nursing	99. Other (specify) _____
	3. Baccalaureate Degree/RN	8. Doctorate in Other Field (specify) _____	
	4. Baccalaureate Degree in Other Field (specify) _____	9. PN Certificate/Diploma	
	5. Masters in Nursing		
Year Advanced Degree was Granted _____			
I am currently taking courses toward an additional/advanced degree in nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I intend to leave/retire from the practice of nursing in the next two years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
States other than Idaho in which I am practicing: _____			

Information provided is for statistical purposes only.

**DECLARATION OF PRIMARY STATE OF RESIDENCE  
NURSING LICENSURE INTERSTATE COMPACT**

Dear Applicant for Licensure:

On July 1, 2001, Idaho became a member of the Nurse Licensure Compact. Other states include Arizona, Arkansas, Colorado, Delaware, Iowa, Kentucky, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin.

Under terms of the Nurse Licensure Compact, nurses may hold a license to practice issued by their state of residence, if that state is a Compact state, and are granted the privilege to practice in other Compact states without holding separate licenses in those other states. If you reside in a Compact state, you may hold a Compact state license only in your declared state of residence; you may not be licensed in any other Compact state. If you reside in a state that is not a member of the Compact and you apply for licensure to practice in any Compact state, you will be issued a license by the individual Compact state that will be designated as valid for practice only in that state.

If you are applying for licensure in Idaho and indicating a mailing address in another Compact state, it is imperative that you inform the Idaho Board as to which scenario best suits your particular situation, to ensure that appropriate procedures are followed in issuing your Idaho license or in directing you to contact the appropriate state(s) to apply for and receive a license.

Please note, if you are in the process of moving to Idaho and declaring Idaho as your state of residence, you must provide the Idaho Board with an Idaho address within 30 days of relocating to this state. Upon notice of address change, licenses held in any other Compact state will become invalid.

More information regarding the Nurse Licensure Compact is available on the National Council of State Boards of Nursing web site at <http://www.ncsbn.org>. If you have questions about your application, please contact the Board at (208) 334-3110 ext. 21.

-----Tear off and return-----

**DECLARATION OF STATE OF RESIDENCE**

Name \_\_\_\_\_

Address: \_\_\_\_\_

Primary state of residence is defined as "the state of a person's declared fixed permanent and principal home for legal purposes; domicile. Documentation of state of residence includes a valid driver's license with a home address, voter registration card with a home address, and/or the state declared as the state of residency on the last federal tax return.

Based on the definition above, my primary state of residence is \_\_\_\_\_

I am currently practicing nursing (including telenursing) in the following states:

Check one:

- I am declaring Idaho as my state of residence, even though my mailing address is in another Compact state.
- I am declaring Idaho as my state of residence; my mailing address is listed below.
- I am practicing in Idaho, but am declaring another Compact state as my state of residence.
- I am practicing in Idaho, but am declaring a Non-Compact state \_\_\_\_\_ as my state of residence.
- I am a member of the armed forces and am declaring Idaho as my state of residence.
- I am in the process of moving to Idaho, but do not yet have an Idaho mailing address.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

**AFFIDAVIT ATTESTING TO VALIDITY OF COPY**

I hereby certify that the attached is a direct photocopy of:  
Please  appropriate box (es).

- The certificate which shows proof of current licensure as a licensed professional nurse (RN)
- The certificate which shows advanced practice professional nurse national certification
- The document which verifies acceptance to take the certification examination
- The diploma from my Advanced Practice Professional Nurse educational program

Total number of documents \_\_\_\_\_  
Signature of Applicant \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, in the year of \_\_\_\_\_, before me  
\_\_\_\_\_, a 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.

(Notary Seal)

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My Commission Expires

AFF APPN 2001

-----Tear Here-----



The following items must be submitted when you file your application for **APPN** licensure:

- Completed, notarized application – pages 1, 2 **and** 3.
- Fee – for Advanced Practice Professional Nurse licensure
- Fee – for Fingerprint processing
- Declaration Form
- Affidavit attesting to the Validity of Copies – attach a copy of your RN license and APPN Certification card
- Fingerprint Card

Be sure that you have requested that an **OFFICIAL TRANSCRIPT** of your advanced practice professional nursing program be submitted directly to the Board office.

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 directly to the Board of Nursing 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](http://www.state.id.us/bop/forms/index.html) (CS)  
[www.deadiversion.usdoj.gov/drugreg/index.html](http://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.**

A F F I D A V I T

State of \_\_\_\_\_ )  
County of \_\_\_\_\_ ) s.s.

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, it is not necessary to 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