APPLICATION FOR APPN LICENSURE

Use this application if:

The Idaho RN license is current

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. **Fingerprint cards are available from the Board office by calling (208) 334-3110 ext 2476.**

Total Fees to be submitted:

APPN Application Fee -	$90.00
Fingerprint Processing Fee -	$30.00
Prescriptive Authorization (if needed) -	$50.00

TOTAL - $170.00 (with prescriptive authorization)
$120.00 (without prescriptive authorization)

APPLICATION INSTRUCTIONS FOR ADVANCED PRACTICE PROFESSIONAL NURSE LICENSURE

This application may be used by nurses applying for:

- Advanced practice professional nurse licensure (CNM, CNS, NP, RNA). *If you are applying for APPN licensure and are not currently licensed to practice in Idaho as a professional nurse (RN), you must apply for professional **and** advanced practice professional nurse licensure and pay both licensure fees.*
- Temporary licensure. *Idaho has a mandatory nurse licensure law requiring nurses to be licensed to practice in Idaho at the time of employment. A temporary license may be issued for an interim period of ninety (90) days while the application for renewable licensure is being processed. Instructions for temporary licensure are included on these instructions.*

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

The following items are required for all applications:

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) Tape a 2 x 2 identification photograph, taken within the last year. Pictures may be passport or digital/Polaroid type. Black & white or color photos are acceptable.
   4) Complete Page 3 indicating your advanced practice education and certification information.

2. **LICENSURE FEE**. Submit the licensure fee, in the form of a personal check, money order or cashier's check payable to the Idaho Board of Nursing, with the application form. (All fees are non-refundable).
   Advanced Practice Professional Nurse (CNM, CNS, NP, RNA) - $90.00
   APPN Temporary License – No Fee

3. **DECLARATION OF STATE OF RESIDENCE**. Complete the enclosed form attesting that your primary residence is Idaho or another non-Compact state.

4. **RN LICENSURE.** Attach verification of your current Idaho RN license to the enclosed Affidavit.

5. **OFFICIAL TRANSCRIPT:** Request an OFFICIAL TRANSCRIPT indicating program completion from the advanced practice professional nursing program, to be mailed directly to the Board of Nursing office. Please note that the final degree must be posted to the transcript. Transcripts may not be faxed.

6. **ADVANCED PRACTICE PROFESSIONAL NURSE NATIONAL CERTIFICATION**. Submit a copy of your current certificate attached to the enclosed affidavit.

7. **FINGERPRINT CARD**. 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.** You must complete and return the enclosed "NonCriminal Justice Applicant Privacy Statement" to the Board office before your license can be issued. To obtain and challenge your FBI Identification Record – go to: **www.fbi.gov/hq/cjisd/fprequest.htm.**

TEMPORARY LICENSURE FOR ADVANCED PRACTICE PROFESSIONAL NURSE APPLICANTS

Advanced practice professional nurse applicants (CNM, CNS, NP, RNA) applying for APPN temporary licensure, who are currently authorized to practice in Idaho under temporary or renewable professional (RN) licensure must submit the completed application form (pages 1-3) and the "Affidavit Attesting to Validity of Copy", attached to one of the following documents:

1. If you hold national certification, submit a copy of your current certificate showing the expiration date; or
2. If you have not yet taken the certification examination, submit a copy of the document that verifies acceptance to take the examination. In addition, evidence of completion of an Advanced Practice Professional Nursing education program is required. If a final transcript is not yet available, submission of one of the following documents is acceptable:
   1). Correspondence received directly (by FAX or mail) from the director of the educational program attesting to completion of all graduation requirements; or
   2) Notarized copy of diploma.

- Over -

Continued

3. 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 under supervision for re-entry into advanced practice professional nursing.

PLEASE BE ADVISED: Licensed professional nurses and advanced practice professional nurses must renew their license(s) by August 31st of every odd-numbered year. Licensed practical nurses must renew their license by August 31st of every even-numbered year. A nurse who applies for licensure on or after March 1st of the year in which the license would ordinarily be renewed, will be issued a license valid until the next renewal period.

IDAHO BOARD OF NURSING
Mailing Address: PO BOX 83720 - BOISE, ID 83720-0061
Location: 280 N 8th St, Suite 210, Boise, ID 83702
(208) 334-3110 ext 2500

APPLICATION FOR LICENSURE - ADVANCED PRACTICE PROFESSIONAL NURSE

For Office Use Only

License #_____

APPN #_____

Receipt#_____

Amount _____

Approval

Temp_____

Licensure_____

Check **all** categories for which application is being made:

- ☐ **Licensed Practical Nurse (LPN)**
  - ○ Licensure by Endorsement
  - ○ Licensure by Reinstatement
- ☐ **Licensed Professional Nurse (RN)**
  - ○ Licensure by Endorsement
  - ○ Licensure by Reinstatement
- ☐ **Advanced Practice Professional Nurse**
  - ○ Certified Nurse-Midwife
  - ○ Clinical Nurse Specialist
  - ○ Nurse Practitioner
  - ○ Registered Nurse Anesthetist
- ☐ **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_____

City_____ State_____ Zip Code_____
City State Zip Code

Telephone – Home/Cell: ( )_____ Work: ( ) _____ S.S. No. _____

Birthplace_____ Birth Date_____
(City & State) (Mo/Day/Year)

BASIC RN/LPN EDUCATION

Name of Practical Nursing (LPN) Education Program _____

Location_____

Dates Attended_____ to _____ Type of Degree/Credential:_____
Mo/Yr Mo/Yr ADN/ASN/CERT/DIPLOMA

Name of Professional Nursing (RN) Education Program_____

Location_____

Dates Attended_____ to _____ Type of Degree/Credential:_____
Mo/Yr Mo/Yr ADN/ASN/BSN/MSN

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? ☐ Yes ☐ No ☐ RN ☐ PN
2. Have you ever been licensed or made application for licensure as an RN/LPN/APPN in Idaho prior to this date? ☐ Yes ☐ No If previous Idaho licensure, indicate year and name used_____
3. State and year of original RN/LPN licensure_____ License No._____
4. List all states in which you are or have ever been licensed_____

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 a 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 contendre or an "Alford plea", 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.

A F F I D A V I T

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.

Signature _____

3/2012

My Commission expires_____

 Applicant Name_____

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 *

* A final 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 National 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.

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.

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, Missouri, 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. 2476.

----------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 (please explain)
- ☐ 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:_____
3/12

Idaho State Police

Bureau of Criminal Identification

NONCRIMINAL JUSTICE APPLICANT PRIVACY STATEMENT

As an applicant who is the subject of a national fingerprint-based criminal history record check for a non-criminal justice purpose you have certain rights which are discussed below.

This serves as notification from the Idaho Board of Nursing that your fingerprints will be used to check the criminal history records of the State of Idaho and the FBI and that those records will be used solely for the purpose requested and may not be disseminated outside the receiving department, related agency or other authorized entity. The collection of applicant fingerprints in Idaho is authorized by Idaho Code §67-3008.

- If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- Procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record, or decline to do so, before being denied the job, license, or other benefit based on information in the criminal history record.
- Disclosure of your Social Security number is voluntary and is solicited pursuant to the Federal Privacy Act and Idaho Code §67-3012 to aid the processing of an interstate background check request for noncriminal justice purposes allowed by federal statute, federal executive order or a state statute that has been approved by the attorney general.

The fingerprints and information reported from this request may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(h)). Routine uses include, but are not limited to, disclosures to appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities or application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks. Depending on the nature of your application, other authorities may include numerous Federal or State statutes pursuant to Public Law 92-544 or other authorized authorities.

According to Idaho state law and if agency policy permits, you may be provided a copy of your FBI criminal history record for review and possible challenge upon submission of a written request. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at http://www.fbi.gov/about-us/cjis/background-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI at the same website address as provided above. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30-16.34)
If a change, correction or update needs to be made to an Idaho criminal history record, that process information is available on the Idaho State Police website.
http://www.isp.idaho.gov/identification/crime_history/FrequentlyAskedQuestions-CriminalRepository.html.

Your signature below acknowledges this agency has informed you of your privacy rights for fingerprint-based background check requests used by the agency for non-criminal justice purposes.

I do ☐ do not ☐ want a copy of the Privacy Act Statement.

Printed Name	Signature of Applicant	Date

Idaho Board of Nursing – PO Box 83720 – Boise, ID 83720-0061

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

----------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 APPN National Certification card
- ⇒ Fingerprint Card
- ⇒ Privacy Statement

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 attached application 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. (The transcript of your advanced practice professional nurse education submitted as part of your APPN licensure application meets this requirement.)

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 (CS)
www.deadiversion.usdoj.gov/drugreg/index.html (DEA)

IDAHO BOARD OF NURSING
Mailing Address: PO BOX 83720 - BOISE, ID 83720-0061
Location: 280 N 8th St, Suite 210, Boise, ID 83702
(208) 334-3110 ext 2500

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_____

Telephone: Home/Cell ( )_____ 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 _____)
) 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 _____ 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.

Signature_____
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: Sen/Fax 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:

_____

_____

_____

PHONE NUMBER: _____ FAX NUMBER: _____

_____ _____

DATE FACULTY SIGNATURE AND TITLE 3/12