APPLICATION FOR AUTHORIZATION TO PRESCRIBE

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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 ☐ NO ☐
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 ☐ NO ☐
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 ☐ NO ☐
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 ☐ NO ☐
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 ☐ NO ☐
6. I CONSENT TO NSCN VERIFYING ANY AND ALL INFORMATION, WHICH MAY INCLUDE CONTACTING EMPLOYERS, INSTITUTIONS OR AUTHORITIES CITED IN MY APPLICATION.	YES ☐ NO ☐
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 ☐ NO ☐
8. I ACKNOWLEDGE THE ANSWERS I PROVIDED ON THE MOST RECENT APPLICATION TO RENEW MY RN REGISTRATION AND LICENSE HAVE NOT CHANGED.	YES ☐ NO ☐
9. I ATTEST THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND ACCURATE.	YES ☐ NO ☐

RN SIGNATURE	DATE

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RN NAME (PRINT)	REGISTRATION NUMBER

SECTION2: 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:	

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RN NAME (PRINT)	REGISTRATION NUMBER

ABOUT RN PRESCRIBER PRACTICE SETTING

THE NURSE NAMED ABOVE IS IN A ROLE WHERE RN PRESCRIBING IS REQUIRED.	YES ☐ NO ☐
ARE THERE ANY EMPLOYER CONDITIONS, RESTRICTIONS, OR LIMITATIONS ON THE RN PRESCRIBERS PRACTICE?	YES ☐ NO ☐
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 ☐ NO ☐
THERE IS AN ESTABLISHED PROCESS TO ENABLE COLLABORATION BETWEEN THE RN PRESCRIBER AND AN APPROPRIATE HEALTH CARE PROVIDER, SUCH AS NP OR PHYSICIAN.	YES ☐ NO ☐
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 ☐ NO ☐

EMPLOYER SIGNATURE	DATE