Oklahoma Board of Nursing
2915 N. Classen Blvd., Suite 524
Oklahoma City, OK 73106
(405) 962-1800
www.ok.gov/nursing

Agreement for Physician Supervising Advanced Practice Prescriptive Authority

Part I: To Be Completed By the Advanced Practice Registered Nurse

1. Name (as it appears on license)_____

2. OK License Number_____

3. Type of advanced practice role held (Check one) _____CNP _____ CNS _____CNM

4. Advanced Practice Certification (specialty) held_____

5. Purpose for Submission of *Agreement for Physician Supervising Advanced Practice Prescriptive Authority* (**Check One**):
   - ___ Initial application for prescriptive authority (submit the *Agreement* with initial application and fee)
   - ___ Addition of a physician (submit the *Agreement* with *Change of Supervising Physician* form and fee)
   - ___ Reinstatement of prescriptive authority (submit the *Agreement* with reinstatement application and fee)
   - ___ Renewal of prescriptive authority (submit the *Agreement* after completing renewal online)

Part II: To Be Completed By the Physician

1. Physician Name _____ MD / DO _____
   First Middle Initial Last (Circle One)

2. Oklahoma License Number _____ Expiration Date _____

3. Work Address _____
   Street City State Zip Telephone #

4. Practice Specialty Area _____

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

6. Do you have a current, unrestricted permit from:
   A. Oklahoma Bureau of Narcotics and Dangerous Drug Control? ___Yes ___No
   B. Drug Enforcement Administration (DEA)? ___Yes ___No

AFFIDAVIT

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 [59 O.S. § 567.3a(11) and (12)].

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

_____ effective _____. I further agree to be available for
Name of Advanced Practice Registered Nurse Date

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 MDs) or Oklahoma State Board of Osteopathic Examiners (for DOs). Further, I certify that the statements contained in this *Agreement* are true and correct.

Signature of Physician _____ MD / DO
(Circle One)

Subscribed to and sworn before me, this _____ day of _____, 2_____.

_____ _____
Commission Expires Notary Public

(STAMP SEAL ONLY)