APRN PRESCRIPTIVE AUTHORITY NOTIFICATION FORM

This form is an official multi-use form. One or more actions may be communicated to the KBN on this form. Please review carefully to ensure you are fully compliant with providing the requested information. Please provide one (1) form per each collaborating physician. All applicable information requested on this form shall be entered or the notification form will be returned to you for completion.

APRN Name (Last, First, Middle Initial)

Collaborating Physician Name (Last, First)

KY APRN License #

KY Physician License #

APRN Population Focus

Physician Specialty

CAPA-NS – Collaborative Agreement for Prescriptive Authority for Non-Scheduled Drugs

_____NOTIFICATION of a CAPA-NS entered into by the APRN and collaborating physician on _____DATE

_____RESCISSION/CHANGE of a CAPA-NS with collaborating physician _____NAME, within 4 years of licensure _____DATE

_____DISCONTINUATION of a CAPA-NS, having met the 4 year practice requirement and will be prescribing without a CAPA-NS _____DATE

CAPA-CS - Collaborative Agreement for Prescriptive Authority for Controlled Substances

_____NOTIFICATION of a CAPA-CS entered into by the APRN and physician on _____DATE

- (DEA required to hold CAPA-CS and copy of DEA registration must be provided to KBN)

_____RESCISSION of CAPA-CS with collaborating physician _____on _____DATE

DEA (controlled substances) & DEA-x (medication assisted treatment)

_____COPY of DEA REGISTRATION(s) from any and all states included with this form. This form and DEA must both be provided and on file

PRACTICE ADDRESS - ***'Current/initial practice address'*** **must be completed when submitting this form**

_____ Notification of change of practice address

Current /Initial practice address

Name of practice

Address of practice

City, State and Zip code

Phone number (Include area code)

Change of practice address

Name of practice

Address of practice

City, State and Zip code

Phone number (Include area code)

By signing and submitting this form to the Kentucky Board of Nursing, I hereby certify that I am currently licensed as an Advanced Practice Registered Nurse (APRN) in the state of Kentucky. I further understand that all information on this notification form is subject to an audit and that falsification of any information contained herein may be cause for disciplinary action.

APRN signature

Email address

Date signed

Upon completion of this form, please return to:

Kentucky Board of Nursing
312 Whittington Parkway, Suite 300
Attn: APRN Licensure Coordinator
Louisville, KY 40222

Form may be emailed to KBN-Cred@ky.gov or faxed to: 502-429-3336

06/18 rk