

**Notification of a Collaborative Agreement for the Advanced Practice Registered Nurse
Prescriptive Authority for Controlled Substances
(CAPA –CS)**

By signing and submitting this form to the Kentucky Board of Nursing, I hereby certify that I am nationally certified as an Advanced Practice Registered Nurse and have been registered, certified, or licensed as an Advanced Practice Registered Nurse in good standing for one (1) year in Kentucky or in another state prior to applying for licensure in Kentucky. I further understand that all information on this notification form is subject to an audit and that falsification of any information contained herein will be cause for disciplinary action.

This notification meets the requirements of KRS 314.042 and 201 KAR 20:057. A CAPA-CS was entered into by the following Advanced Practice Registered Nurse and physician on _____ (Date).

All information on this notification form must be completed or the notification form will be returned to you for completion.

APRN Last Name (print clearly)

Physician Last Name (print clearly)

APRN First Name (print clearly)

Physician First Name (print clearly)

Kentucky APRN License #

License #

Certification Specialty

Specialty

DEA number * _____

*** You must provide a copy of your DEA license(s) from all states when returning this form or when it is initially issued.**

APRN signature

Date signed

Name of practice

Address of practice

City

State

Zip Code

Phone Number (_____) _____
Include area code

Upon completion of this form, please upload to the APRN portal at: <https://kbnapps.ky.gov/kbnaudit/account/login>.

