RESCISSION
of a Collaborative Agreement for the Prescriptive Authority for Non-Scheduled Legend Drugs (CAPA -NS)

By signing and submitting this form to the Kentucky Board of Nursing, I hereby certify that the Collaboration Agreement for APRN Prescriptive Authority for Non-Scheduled Legend Drugs (CAPA -NS) between the parties listed below is rescinded as of this_____day, in the month of _____, in the year of_____.

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

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APRN Last Name (print clearly)

Physician Last Name (print clearly)

APRN First Name (print clearly)

Physician First Name (print clearly)

Kentucky APRN License #

Physician License #

This form must be signed by at least one of the parties listed above.

APRN signature

Physician signature

Date signed

Date signed

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

Practice Name

Practice Address

Practice City, State and Zip Code

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