Notification to Discontinue the CAPA-NS After Four Years

By signing and submitting this form to the Kentucky Board of Nursing, I hereby certify that I have met the four (4) year requirement and I will be prescribing nonscheduled legend drugs without a CAPA-NS. 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 form meets the requirements of KRS 314.042 and 201 KAR 20:057.

_____

APRN Last Name (print clearly)

_____

APRN First Name (print clearly)

_____

Kentucky APRN License #

_____

APRN signature

_____

Date signed

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

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

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