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.

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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 #

License #

Population Focus

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 return to:

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

Form may also be faxed to: 502-429-3336

12/2014 rk