## *Notification of a Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs (CAPA–NS)*

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 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 will be cause for disciplinary action.

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

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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

_____
APRN signature

_____
Date signed

_____
Name of practice

_____
Address of practice

_____ _____ _____
City State Zip Code

Phone Number (_____) _____
Include area code

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 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