

APPLICATION FOR REINSTATEMENT OF PRESCRIPTIVE WRITING PRIVILEGES

Fee: \$125.00 and is non-refundable

Prescriptive Authority privilege is on a two (2) YEAR CYCLE. Reinstatement applications and supporting documents required must be received in the Board office within sixty (60) days of receipt of this application. The privileges once reinstated, will expire June 30, 2011.

WV Prescriptive Authority Number _____ Advanced Practice Certification _____ Expires _____

Name and Credentials of Advanced Practitioner _____

Home Address _____ Zip _____

Home Phone _____ Email Address _____

Work Address _____ Zip _____

Work Phone _____ Email Address _____

Social Security Number ____ - ____ - ____ Date of Birth ____ - ____ - ____ WV RN License # _____

Do you have DEA Registration?
(Circle One) YES NO If yes, send copy of certificate with renewal

Have you ever been convicted of a felony that has not been previously reported to the Board?
(Circle One) YES NO If yes, send additional information

Have you ever been convicted of a misdemeanor, or pled nolo contendere or deferred prosecution, or been pardoned in relation to any crime that has not been previously reported to the Board? (Any conviction exclusive of minor traffic violations such as speeding or parking violations must be reported)
(Circle One) YES NO If yes, send additional information

Do you have any criminal charges currently pending in any state, territory or country that have not been previously reported to the Board?
(Circle One) YES NO If yes, send additional information

Has a complaint ever been filed against your RN license in West Virginia that has not been dismissed?
(Circle One) YES NO If yes, send additional information

Has a complaint ever been filed against your RN license in any other state, territory or country that has not been previously reported to the WV RN Board?
(Circle One) YES NO If yes, send additional information

Are disciplinary charges pending against any license in this state or any other state, territory or country that have not been previously reported to the Board?
(Circle One) YES NO If yes, send additional information

Has your nursing practice ever been monitored for any reason, disciplinary action or otherwise, by any facility, board or group that has not been previously reported to the Board? (Action includes monetary assessments or fines)
(Circle One) YES NO If yes, send additional information

Have you ever or are you currently abusing prescription or over-the-counter medication?
YES NO

Have you ever or are you currently using illegal drugs?
YES NO

Is there any reason why your access to narcotics or substances of abuse should be restricted or limited?
YES NO

Do you currently possess any condition which may affect your ability to safely and effectively practice registered professional nursing?
(Circle One) YES NO If yes, send a written explanation

Do you have a court ordered child support obligation?
(Circle One) YES NO

Does the amount of any unpaid obligation equal or exceed the amount of child support payable for six (6) months?
(Circle One) YES NO

Are you currently the subject of a child-support or paternity subpoena?
(Circle One) YES NO

Do you own all or part of a business that operates within West Virginia?
(Circle One) YES NO If YES, list the FEIN# _____

WV Code 21A-2-6(18) provides that a board may not issue or renew a license for you to engage in the practice of a profession, if you are in default under either the unemployment compensation laws or the worker's compensation laws, or both laws of this State.

CONTINUING EDUCATION: Attach a copy of certificates showing completion of eight (8) hours of CE in Advanced Pharmacology obtained after June 30, 2007 and not used for reinstatement purposes during 2007-2009.

PRESCRIPTION FORM: Attach a voided sample of your current prescription form. FEE: \$125.00 for reinstatement and is non-refundable.

CERTIFIED COPY OF COLLABORATIVE AGREEMENT: Attach a notarized copy of your collaborative agreement(s). This is in addition to the completion of the verification on this application.

VERIFICATION OF A COLLABORATIVE AGREEMENT FOR PRESCRIPTIVE WRITING PRIVILEGES

(Complete for each collaborative physician)

I _____ (license number ____/RXA number ____) certify by my signature that a written collaborative agreement exists between myself and Dr. _____ (license number _____), and that written guideline/protocols for prescriptive practice are signed and in place. My collaborative agreement with Dr. _____ begins on _____, expires on _____ (cannot exceed expiration date of 06/30/2011) and expires with termination of my employment. Both myself and the above named physician have read and understand the regulations pertaining to prescriptive writing privileges (Federal and State prescribing laws including West Virginia Code for Registered Professional Nurses §30-7-15a,b,c; §30-15-7a,b,c for midwives; and West Virginia Legislative Rule §19CSR8). I understand that for prescriptive writing privileges, the collaborative agreement includes, but is not limited to, the following:

(Please check to indicate completion)

- Mutually agreed upon written guidelines or protocols for prescriptive authority as it applies to the advanced nurse practitioner's prescriptive practice. I have listed below protocols the guidelines and protocols used in my practice.

- Statements describing the individual and shared responsibilities of the advanced nurse practitioner and the physician pursuant to the collaborative agreement between them are listed below:

- Periodic and joint evaluation of prescriptive practice will occur as listed below: Frequency of record review _____ Number of records reviewed _____; and

- Periodic and joint review and updating of the written guidelines or protocols will occur _____(frequency).

I further understand that I must assure that current information regarding collaborative agreements is **on file at the Board office**. I understand that I must have at least one current collaborative agreement verification on file at the Board office at all times. When my collaborative agreement is no longer valid (i.e. dissolution of agreement, agreement not renewed, termination of my employment), I understand that I am to notify the Board office immediately. I further understand that my prescribing privileges are for practice only in the state of West Virginia and that my prescribing practice may be audited/reviewed by the Board. I will practice according to Federal and State Law, the standards of practice in my specialty area, my education and documented competence.

Furthermore, I, the undersigned, being duly sworn, according to law, do depose and say that I am the person making this application; that the statements therein are true to the best of my knowledge and belief; that I have read and understand the Law and Rule pertaining to prescriptive authority; I understand that failure to comply with requirements for licensure, and that knowingly supplying false information on or with this verification is a violation of WV Code §30-7-1 et. seq. and subjects me to the full range of disciplinary action described therein.

Name of Applicant: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

Name of Physician: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

Applicant's Signature _____ Date: _____

Physician's Signature _____ Date: _____

SUBSCRIBED AND SWORN TO BEFORE ME this _____ day of _____, 20__

My commission expires _____.

(SEAL)

Notary Public