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STATE OF DELAWARE  
**DEPARTMENT OF STATE**  
DIVISION OF PROFESSIONAL REGULATION  
**BOARD OF MEDICAL LICENSURE AND DISCIPLINE**

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: DPR.DELAWARE.GOV

**PHYSICIAN ASSISTANT APPLICATION FOR PRESCRIPTIVE AUTHORITY**

**INSTRUCTIONS**

**When to File Prescriptive Authority Application**

This is an application to be granted authority to prescribe by the Board of Medical Licensure and Discipline. File this application when:

- You have applied for a Delaware Physician Assistant license but chose not to apply for prescriptive authority at the same time.
- You already hold a Delaware Physician Assistant license but have not yet applied for prescriptive authority.
- You already hold a Delaware Physician Assistant license with prescriptive authority and are reporting change of:
  - Supervising physician(s)
  - Controlled substance schedules that you are authorized to prescribe

If you have not yet applied for your Delaware Physician Assistant license, STOP. Do not file this form. See [Application for a License to Practice as a Physician Assistant in Delaware](#), available on [www.dpr.delaware.gov](http://www.dpr.delaware.gov), to apply for both Physician Assistant licensure and prescriptive authority.

**Important Information about Controlled Substance Registration**

If you receive prescriptive authority, you may prescribe **only non-controlled substances**. To prescribe controlled substances in Delaware, you must have **all** of the following:

- Delaware PA license **with** prescriptive authority
- At least one supervising physician for *each* individual business/practice where you practice in Delaware
- Delaware CSR
 

**Note:** If you practice at more than one business/practice, you need only a single CSR to **prescribe** at all of the locations. However, every Delaware location where controlled substances are dispensed/stored must be covered by a CSR. If no other practitioner (e.g., physician), physician assistant or APN holds a Delaware CSR for a location where you will **store/dispense**, as well as prescribe, controlled substances, you must file for an additional CSR for the location.
- Federal DEA registration for Delaware (a DEA registration in another jurisdiction is not sufficient)

To apply for a CSR(s), see [Controlled Substances Application for Advanced Practice Nurses](#), available on [dpr.delaware.gov](http://dpr.delaware.gov). For Federal DEA registration, see [DEA New Registration Applications](#).

**TYPE OF APPLICATION** – To be completed by Physician Assistant

1. Select reason for submitting this form:

- I have applied for a Delaware Physician Assistant license but I did not apply for prescriptive authority at the same time.
- I already hold an active Delaware Physician Assistant license but I do not have prescriptive authority. Enter license number: **C5-** \_\_\_\_\_
- I already hold a Delaware Physician Assistant license, license number: **C5-** \_\_\_\_\_ and I *already have prescriptive authority*. I am reporting the following change:
  - My supervising physician has changed. (This includes both new or additional supervisors.)
  - The controlled substance schedules that I am authorized to prescribe has changed.

2. I am applying for prescriptive authority for:

- Controlled and Non-Controlled Substances
- Non-Controlled Substances Only

**Alert:** This is NOT an application for Controlled Substance Registration. See Instructions.

**IDENTIFYING AND CONTACT INFORMATION** – To be completed by Physician Assistant

3. Full Name: \_\_\_\_\_  
Last First Middle

4. Other Names Used: \_\_\_\_\_
5. Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City State Zip
6. Phone: \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Email: \_\_\_\_\_

**LOCATION OF PRACTICE – To be completed by Physician Assistant**

7. Complete the following information about **each** individual business/practice where you will be practicing in Delaware.

**FIRST PRACTICE**

Business/Practice Name: \_\_\_\_\_

**Location** Address: \_\_\_\_\_  
 (If more than one location, enter main location. No PO Box!)

\_\_\_\_\_ DE \_\_\_\_\_  
 City State Zip

Business Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Will you be prescribing controlled substances at any location of this business/practice? Yes  No

**PRACTICE 2**

Business/Practice Name: \_\_\_\_\_

**Location** Address: \_\_\_\_\_  
 (If more than one location, enter main location. No PO Box!)

\_\_\_\_\_ DE \_\_\_\_\_  
 City State Zip

Business Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Will you be prescribing controlled substances at any location of this business/practice? Yes  No

**PRACTICE 3**

Business/Practice Name: \_\_\_\_\_

**Location** Address: \_\_\_\_\_  
 (If more than one location, enter main location. No PO Box!)

\_\_\_\_\_ DE \_\_\_\_\_  
 City State Zip

Business Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Will you be prescribing controlled substances at any location of this business/practice? Yes  No

**If you need more room to list additional Delaware business/practice(s), provide the same information on a separate sheet and enclose it with the application.**

8. Enter the names of **all** physicians who will supervise you, regardless of business/practice or location:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Arrange for each supervising physician you listed above to submit a *Statement of Supervising Physician* (see next page). Enclose all statements with the application.**

9. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes  No

If you have additional supervising physicians, you may copy this page.

### STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: \_\_\_\_\_
2. Delaware Physician License Number: **C** \_\_\_ - \_\_\_\_\_ 3. Specialty: \_\_\_\_\_
4. DEA Numbers: \_\_\_\_\_  
Federal Delaware
5. Which controlled substance schedules are you authorized to prescribe?  II  III  IV  V
6. **Which controlled substance schedules is the Physician Assistant applicant authorized to prescribe under your supervision?**  II  III  IV  V
7. Are you delegating authority to the Physician Assistant applicant to request and issue professional samples of controlled legend medications? Yes  No  **If yes, as the supervising physician, you remain ultimately responsible for prescribing, dispensing and storing the controlled substances even though you are delegating authority to the PA.**
8. **As the supervising physician, I understand that I may not at any given time supervise more than two physician assistants, unless a regulation of the Board increases or decreases the number (24 Del C. §1771(e)).** Yes  No
9. How many Physician Assistants do you currently supervise? \_\_\_\_\_
10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes  No

**Signature of Supervising Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: \_\_\_\_\_
2. Delaware Physician License Number: **C** \_\_\_ - \_\_\_\_\_ 3. Specialty: \_\_\_\_\_
4. DEA Numbers : \_\_\_\_\_  
Federal Delaware
5. Which controlled substance schedules are you authorized to prescribe?  II  III  IV  V
6. **Which controlled substance schedules is the Physician Assistant applicant authorized to prescribe under your supervision?**  II  III  IV  V
7. Are you delegating authority to the Physician Assistant applicant to request and issue professional samples of controlled legend medications? Yes  No  **If yes, as the supervising physician, you remain ultimately responsible for prescribing, dispensing and storing the controlled substances even though you are delegating authority to the PA.**
8. **As the supervising physician, I understand that I may not at any given time supervise more than two physician assistants, unless a regulation of the Board increases or decreases the number (24 Del C. §1771(e)).** Yes  No
9. How many Physician Assistants do you currently supervise? \_\_\_\_\_
10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes  No

**Signature of Supervising Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## CERTIFICATION

I declare and affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

**Signature of Physician Assistant:** \_\_\_\_\_ **Date:** \_\_\_\_\_