



CANNON BUILDING
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DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF NURSING

TELEPHONE: (302) 744-4500
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APPLICATION FOR PRESCRIPTIVE AUTHORITY FOR ADVANCED PRACTICE REGISTERED NURSE INSTRUCTION SHEET

When to File Application

File this application when...

- You hold, or have applied for, a Delaware APRN license, **and**
- You chose not to apply for prescriptive authority when you applied for your APRN license **or** you applied but were not granted prescriptive authority.

If you have not yet applied for your Delaware APRN license, see [Application for Licensure as an Advanced Practice Registered Nurse](#). The application for prescriptive authority is included in it.

Prescriptive authority alone does **not** allow you to prescribe controlled substances in Delaware. See the **Important Information about Prescribing Controlled Substances** section below.

Requirements

- Submit completed, signed [Advanced Practice Registered Nurse Application for Prescriptive Authority](#).
- Arrange for the Board office to receive a transcript(s) that **clearly shows** that you have completed academic courses in all of the following:
 - advanced health assessment
 - diagnosis and management of problems within your clinical specialty
 - advanced patho-physiology
 - advanced pharmacology/pharmacotherapeutics.

If you have already arranged for the Board office to receive an official transcript from your APRN program or if the Board received the transcript when you filed your APRN application, you don't need to have the transcript sent again.

- Use the following table to decide if you must submit documentation of continuing education **in (or related to) advanced pharmacology and pharmacotherapeutics**. Acceptable documentation is the completion certificate you receive at the end of the educational activity. Documents such as copies of your course registration or letters/emails thanking you for registering are **not** acceptable proof that you completed the coursework.

IF you...	THEN ...
completed your APRN program within the two years before submitting this application	you do <i>not</i> need to submit proof of any continuing education.
hold a current, unencumbered APRN license in another jurisdiction (state, U.S. territory or District of Columbia) and that license is clearly marked with prescriptive authority	submit <ul style="list-style-type: none"> • copy of the license • documentation that you have completed at least 10 hours continuing education in (or related to) advanced pharmacology and pharmacotherapeutics during the past two years.
<ul style="list-style-type: none"> • completed your APRN program more than two years before you submit this application, and • do not have prescriptive authority in another jurisdiction 	submit documentation that you have completed at least 30 hours continuing education in (or related to) advanced pharmacology and pharmacotherapeutics during the past two years.

Important Information about Controlled Substance Registrations

This application for prescriptive authority is *not* an application for Delaware Controlled Substance Registration (CSR). To prescribe controlled substances in Delaware, you must have ***all*** of the following:

- Delaware APRN license ***with*** prescriptive authority
- 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 APRN 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 Registration – Advanced Practice Registered Nurses](#). For Federal DEA registration, see [DEA New Registration Applications](#).



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TYPE OF APPLICATION

1. Select reason for submitting this form:

- I hold an active Delaware APRN license number: L ____ - _____ but I do not have prescriptive authority.
 I have applied for a Delaware APRN license, but I did not apply for prescriptive authority at the same time.

IDENTIFYING AND CONTACT INFORMATION

2. Full Name: _____
Last First Middle
3. Other Names Used: _____
4. Mailing Address: _____

City State Zip
5. Phone: _____ Email: _____
Home Work

ADVANCED EDUCATION

6. Enter the name of the colleges/universities where you completed the academic courses in advanced health assessment, diagnosis and management of problems within your clinical specialty, advanced patho-physiology and advanced pharmacology/pharmacotherapeutics.

College/University: _____

College/University: _____

College/University: _____

Arrange for the Board office to receive a transcript(s) *clearly showing* that you have completed the required academic coursework. If you have already arranged for the Board office to receive an official transcript from your APRN program or the Board has already received your transcript in connection with your APRN licensure application, you don't need to have the transcript sent again.

CONTINUING EDUCATION

7. Did you complete your APRN program within the two years before submitting this application? Yes No **If yes, skip to the CERTIFICATION section. If no, continue with the next question.**
8. Do you hold a current, unencumbered APRN license with prescriptive authority in another jurisdiction (state, U.S. territory or District of Columbia)? Yes No
- **If yes, submit a copy of your license *clearly marked* with prescriptive authority *and* completion certificates for 10 hours of continuing education in advanced pharmacology and pharmacotherapeutics during the past two years.**
 - **If no, submit completion certificates for 30 hours of continuing education in advanced pharmacology and pharmacotherapeutics during the past two years.**

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 Advanced Practice Nurse: _____ **Date:** _____

OFFICE USE ONLY
Prescriptive Authority
<input type="checkbox"/> Approved on : _____
<input type="checkbox"/> Not approved - reason: _____
By: _____