



FORM A

VERIFICATION OF PRESCRIPTIVE AUTHORITY
NOT AUTHORIZED to Prescribe Controlled Substances

APPLICANT: Please complete and forward to the state (any jurisdiction of the National Council of State Boards of Nursing) or to the place of employment within the U.S. Government where you hold/held valid authority to prescribe drugs and therapeutic devices, excluding controlled substances, for a continuous period of at least one year during the three years immediately preceding the date of the CTP application. Contact the verifying state for fee information.

Name (Last) (First) (Middle) (Maiden)

Social Security Number\* Date of Birth

Address

City State Zip

STATE LICENSURE INFORMATION

License/Certificate # Issue Date Expiration Date

Name under which license/certificate was issued (Last) (First) (Middle)

U.S. GOVERNMENT EMPLOYMENT INFORMATION

U.S. Government Agency

(Identify branch of service, federal installation or Veterans' Administration Employment)

Employment Dates: From (Month/Year) To (Month/Year)

I hereby authorize the (please list state) State Board of Nursing or the U.S. Government to provide the Ohio Board of Nursing with the information requested in Part 2.

Signature Date

\*Your social security number is required by state and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the National Practitioner Data Bank (Public Law 100-93, Sec. 1921 of the Social Security Act, as amended; 45 C.F.R. pt. 60); reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

**BOARD OF NURSING OR U.S. GOVERNMENT REPRESENTATIVE:** Please complete the sections below and mail directly to the Board.

Ohio Board of Nursing  
Attn: APRN Unit  
17 South High Street, Suite 400  
Columbus, OH 43215-7410

Name of Nurse \_\_\_\_\_

License/Certificate # \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Current license/certificate status:  Active  Inactive  Lapsed

Does this nurse have authority to prescribe drugs and therapeutic devices, excluding controlled substances?

Yes  No

Is there any pending disciplinary action against this license/certificate?  Yes (If yes, attach explanation)  No

Has this license/certificate ever been encumbered (revoked, suspended, surrendered, restricted, limited, placed on probation, etc.)?  Yes (If yes, attach explanation)  No

**THIS SECTION IS TO BE COMPLETED BY THE STATE BOARD OF NURSING REPRESENTATIVE**

I certify that the above information accurately represents the information on file with the State Board of Nursing, for the above named nurse.

Signed and the State Board of Nursing seal affixed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signature \_\_\_\_\_ Title \_\_\_\_\_ State \_\_\_\_\_

(STATE SEAL)

**THIS SECTION IS TO BE COMPLETED BY THE U.S. GOVERNMENT REPRESENTATIVE**

I certify that the above information accurately represents the information on file with

\_\_\_\_\_, for the above named nurse.

(Identify branch of service, federal installation or Veterans' Administration employment)

Signature of U.S. Government Employer \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_