

**NOTICE OF DELEGATED PRESCRIPTIVE AUTHORITY
FOR CONTROLLED SUBSTANCES
(Advanced Practice Registered Nurse)**

Please Print

Name of APRN (Last, First, Middle Initial) _____

RN license number _____

APRN Document of Recognition number (if different from RN license) _____

Physician Statement:

This is to attest and certify that I, _____, have
delegated _____ Collaborating Physician

independent prescriptive authority to, _____ in
order to _____ Advanced Practice Registered Nurse

prescribe controlled substances categorized as Schedule III, IV, V and only
medications containing Hydrocodone from Schedule II, as defined in 195.017 RSMo.
Under this delegated authority, and pursuant to the limitations of the collaborative
practice arrangement, the APRN may issue orders and otherwise prescribe
controlled substances without prior notice from or contact with me.

I also attest and certify that the use of the substances for which I have delegated
independent controlled substance prescriptive authority is consistent with the
education, knowledge, skill and competence of myself and the APRN listed.

I further attest that I am a Missouri licensed physician with an unrestricted federal
DEA number and am actively engaged in a practice comparable in scope, specialty,
or expertise to that of the APRN listed above.

Physician Signature

Physician Name Printed

Date