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 independent prescriptive authority to, ___________________________________, in
order to 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

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Date

Revised 10/2011, 8/2015