

# Instructions for the Physician Assistant Application for Certificate of Controlled Substance Prescriptive Authority

Attached are the materials you will need to make application for the physician assistant certificate of controlled substance prescriptive authority.

**Prior to completing the application, you should read the statutes and rules governing physician assistants in the State of Missouri. These are located on our website at <http://pr.mo.gov/healingarts-rules-statutes.asp>.**

## **FEE**

The fee is \$25. Please make checks payable to the **Missouri Board of Healing Arts**. All checks must be drawn on a United States bank because our bank doesn't accept checks from International banks. No application will be processed until the fee is received. The Board cannot accept credit or debit cards for payment of the initial application fee.

## **ARMED FORCES OF THE UNITED STATES**

If you have ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable; or if you are the spouse of an active duty member of the Armed Forces of the United States, you may qualify for additional services. If applicable, please complete the form included in the application and return it with your application, along with verification of military status.

## **DOCUMENTS THAT NEED TO BE SUBMITTED IN ADDITION TO THE FORMS IN THIS PACKET**

- Official transcripts or a letter from your program director documenting successful completion of an advanced pharmacology course that includes clinical training in the prescription of drugs, medicines, and therapeutic devices. A course or courses with advanced pharmacological content in a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency shall satisfy such requirement.
- Official transcripts or a letter from your program director documenting completion of a minimum of one year of supervised clinical practice or supervised clinical rotations. One year of clinical rotations in a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency, which includes pharmacotherapeutics as a component of its clinical training, shall satisfy such requirement. Proof of such training shall serve to document experience in the prescribing of drugs, medicines, and therapeutic devices.

## **HOW TO CHECK THE STATUS OF YOUR APPLICATION**

When your application is received and processed, you will be notified via email regarding the status of your application.

**If you have questions** after reading these instructions, you may call the Board office at 573-751-0098 or toll free at 866-289-5753 or email at [licensure@pr.mo.gov](mailto:licensure@pr.mo.gov).



STATE OF MISSOURI  
 DIVISION OF PROFESSIONAL REGISTRATION  
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS  
**PHYSICIAN ASSISTANT APPLICATION FOR CERTIFICATE OF  
 CONTROLLED SUBSTANCE PRESCRIPTIVE AUTHORITY**

STATE BOARD OF REGISTRATION FOR HEALING ARTS  
 3605 MISSOURI BLVD, PO BOX 4  
 JEFFERSON CITY, MO 65102  
 TELEPHONE: (573) 751-0098  
 TOLL FREE: (866) 289-5753  
 TTY: (800) 735-2966

**Please complete and return this application, proof of meeting educational requirements, collaborating physician certification of controlled substance prescribing authority form and fee of \$25, made payable to the Missouri State Board of Healing Arts, to P.O. Box 4, Jefferson City, MO 65102.**

PHYSICIAN ASSISTANT NAME (LAST, FIRST, MIDDLE, MAIDEN) (PLEASE PRINT)	MISSOURI LICENSE NUMBER	EMAIL ADDRESS
COLLABORATING PHYSICIAN NAME (PLEASE PRINT)	MISSOURI LICENSE NUMBER	

**THIS SECTION TO BE COMPLETED BY PHYSICIAN ASSISTANT**

I hereby certify that I have attached proof of:

1. Official transcripts or a letter from my program director documenting successful completion of an advanced pharmacology course that includes clinical training in the prescription of drugs, medicines, and therapeutic devices. A course or courses with advanced pharmacological content in a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency shall satisfy such requirement;
2. Documentation from my collaborating physician of completion of a minimum of three hundred clock hours of clinical training by the collaborating physician in the prescription of drugs, medicines, and therapeutic devices; and
3. Official transcripts or letter from my program director documenting completion of a minimum of one year of supervised clinical practice or supervised clinical rotations. One year of clinical rotations in a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency, which includes pharmacotherapeutics as a component of its clinical training, shall satisfy such requirement. Proof of such training shall serve to document experience in the prescribing of drugs, medicines, and therapeutic devices.

**APPLICANT'S OATH**

STATE/PROVINCE OF \_\_\_\_\_

COUNTY/PARISH OF \_\_\_\_\_

I, \_\_\_\_\_, hereby certify under oath that I am the person named in this application for a **CERTIFICATE OF CONTROLLED SUBSTANCE PRESCRIPTIVE AUTHORITY**; that all statements I have made herein are true and that I have personally read, reviewed and answered each of these questions; I understand that:

- I may prescribe any controlled substances listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II - hydrocodone as delegated to me by my collaborating physician and as stated in my collaborative practice arrangement;
- Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician;
- I shall not prescribe controlled substances for myself or members of my family as defined in the Board's Rule 20 CSR 2150-7.010(1);
- I must obtain a registration from the Drug Enforcement Administration (DEA) and the State Bureau of Narcotics and Dangerous Drugs (BNDD) prior to prescribing controlled substances and shall include such registration numbers on prescriptions for controlled substances;
- I cannot prescribe controlled substances until I have received a certificate of controlled substance prescriptive authority from the Board and registrations from the DEA and BNDD;
- The delegated authority to prescribe is consistent with my and my collaborating physician's education, knowledge, skill and competence;
- Any limitations on my collaborating physician or my ability to practice shall be listed on the collaborating physician certification of delegation of controlled substance prescribing authority form;
- If my collaborating physician changes, then I must provide the Board with a new collaborative practice arrangement form prior to prescribing controlled substances under the new collaborating physician's authority.
- All documents submitted with this application or as part of the application process that are original, or duplicated copies of the originals, have not been altered in any fashion whatsoever;

I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this application.

I have read Chapter 334 RSMo, Chapter 195 RSMo, 20 CSR 2150-7 and 19 CSR 30 which contains the Statutes, Rules and Regulations governing the prescribing of controlled substances and the practice of physician assistants;

I have answered all questions truthfully and in compliance with the instructions provided:

I understand that the application fee submitted with this application is non-refundable and cannot be transferred to another application.

**MUST BE SIGNED IN THE PRESENCE OF NOTARY**

APPLICANT'S SIGNATURE		DATE
NOTARY PUBLIC EMBOSSEER OR BLACK INK RUBBER STAMP SEAL	STATE	COUNTY
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR	
	<b>USE RUBBER STAMP IN CLEAR AREA BELOW.</b>	
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
NOTARY PUBLIC NAME (TYPED OR PRINTED)		



STATE OF MISSOURI  
 DIVISION OF PROFESSIONAL REGISTRATION  
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS  
**COLLABORATING PHYSICIAN CERTIFICATION  
 OF CONTROLLED SUBSTANCE PRESCRIBING AUTHORITY**

STATE BOARD OF REGISTRATION FOR HEALING ARTS  
 3605 MISSOURI BLVD, PO BOX 4  
 JEFFERSON CITY, MO 65102  
 TELEPHONE: (573) 751-0098  
 TOLL FREE: (866) 289-5753  
 TTY: (800) 735-2966

COLLABORATING PHYSICIAN NAME	MISSOURI LICENSE NUMBER
------------------------------	-------------------------

NAME OF PHYSICIAN ASSISTANT

I hereby certify that the above-named physician assistant has completed a minimum of three hundred clock hours of clinical training by me in the prescription of drugs, medicines, and therapeutic devices.

I hereby certify that I have delegated to the above-named physician assistant the authority to prescribe the listed controlled substances, as indicated below.

- Schedule III, IV and V of section 195.017 and Schedule II - hydrocodone with no limitations;
- Schedule III, IV and V of section 195.017 and Schedule II - hydrocodone with the below listed limitations:
- Schedule III and IV of section 195.017 and Schedule II - hydrocodone only with no limitations;
- Schedule III and IV of section 195.017 and Schedule II - hydrocodone with the below listed limitations:
- Schedule II - hydrocodone only;
- Schedule II - hydrocodone with the below listed limitations:
- Schedule III only;
- Schedule III with the below listed limitations:
- Schedule IV only;
- Schedule IV with the below listed limitations:
- Schedule V only;
- Schedule V with the below listed limitations:
- Other (list below, add additional sheets if necessary);

In addition to the above, please list any limitations on your practice or the physician assistant's practice (i.e. physician is restricted from prescribing Schedule III, physician required to complete triplicate prescription forms, etc.)

I further certify that:

The above-named physician assistant shall prescribe any controlled substances listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Section II - hydrocodone as delegated by me to the physician assistant and as stated in the collaborative practice arrangement;

I will confirm that the Board of Healing Arts has issued a certificate of controlled substance prescriptive authority and that the DEA and BNDD has issued registrations to the above-named physician assistant, prior to the prescribing of controlled substances;

I will determine and document as required by Section 334.747, RSMo, the completion of at least 120 hours in a four-month period during which the above-named physician assistant will practice with me on-site before the physician assistant may prescribe controlled substances when I am not on-site. I acknowledge this obligation applies except to the extent the above-named physician assistant is practicing in a population-based public health service, as defined in 20 CSR 2150-5.100, as of April 30, 2009.

Schedule III controlled substances and Schedule II - hydrocodone prescriptions prescribed by the above-named physician assistant shall be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician;

The above-named physician assistant shall not prescribe controlled substances for themselves or members of their family, as the term "family" is defined in the Board's Rule 20 CSR 2150-7.010(1);

The above-named physician assistant must register with the Drug Enforcement Administration and the State Bureau of Narcotics and Dangerous Drugs and shall include such registration numbers on prescriptions for controlled substances;

The delegated authority to prescribe is consistent with each professional's education, knowledge, skill and competence;

Any limitations on me or the physician assistant's ability to practice shall be listed on the collaborating physician certification of delegation of controlled substance prescribing authority form;

In accordance with Rule 20 CSR 2150-7.122, I will notify the Board within 15 days if my collaboration with of the above-named physician assistant ceases;

I have read Chapter 334 and Chapter 195, RSMo, which contains the Statutes, Rules and Regulations governing the prescribing of controlled substances by physician assistants.

**MUST BE SIGNED IN THE PRESENCE OF NOTARY**

COLLABORATING PHYSICIAN'S SIGNATURE		DATE
NOTARY PUBLIC EMBOSSEER OR BLACK INK RUBBER STAMP SEAL	STATE	COUNTY
	SUBSCRIBED AND SWORN BEFORE ME, THIS	
	DAY OF	YEAR
	<b>USE RUBBER STAMP IN CLEAR AREA BELOW.</b>	
NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
NOTARY PUBLIC NAME (TYPED OR PRINTED)		



STATE OF MISSOURI  
DIVISION OF PROFESSIONAL REGISTRATION  
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS  
3605 MISSOURI BLVD., P.O. BOX 4  
JEFFERSON CITY, MO 65102 TELEPHONE (573) 751-0098  
TOLL FREE (866) 289-5753

## ARMED FORCES OF THE UNITED STATES

(1) Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? \_\_\_ Yes \_\_\_ No

(2) Are you the spouse of an active duty member of the Armed Forces of the United States? \_\_\_ Yes \_\_\_ No

If you answered questions (1) or (2) in the affirmative, please see the information below regarding the agency's veteran services and return this form with verification of military status.

- Upon proof and approval, you may qualify for:
  - Expedited Application Processing pursuant to section(s) 324.006 and 324.007, RSMo.
  - Military Education, Training and Service Toward Licensure Qualification pursuant to section 324.007, RSMo.
  - Licensure Reciprocity pursuant to section 324.009, RSMo.
  - Fee Waiver Request pursuant to section 324.015, RSMo.

Veterans taking professional state licensing or certification examinations required by the Department of Commerce & Insurance (DCI) can be reimbursed for the cost of the exam. Visit the Missouri Department of Elementary and Secondary Education's [Veterans Education website](#) to learn more about how the GI Bill can pay the cost of a license or certification test.

---

Name (Please Print)

---

Email Address

---

Address

---

City

---

State

---

Zip Code



STATE OF MISSOURI  
DIVISION OF PROFESSIONAL REGISTRATION  
STATE BOARD OF REGISTRATION FOR THE HEALING  
ARTS 3605 MISSOURI BLVD., P.O. BOX 4 JEFFERSON  
CITY, MO 65102  
TELEPHONE (573) 751-0098  
FAX (573) 751-3166  
EMAIL LICENSURE@PR.MO.GOV

## PHYSICIAN ASSISTANT COLLABORATIVE PRACTICE ARRANGEMENT

I am the:      \_\_\_ Primary Collaborating Physician      \_\_\_ Alternate Collaborating Physician

\_\_\_\_\_  
PHYSICIAN NAME

\_\_\_\_\_  
PHYSICIAN LICENSE NUMBER

\_\_\_\_\_  
PHYSICIAN ASSISTANT NAME

I certify I have entered into a collaborative practice arrangement with the above-named physician assistant, as provided in sections 334.735 through 334.749, RSMo, and the board's rules governing collaborative practice arrangements. I have delegated authority to the physician assistant consistent with the physician assistant's skill, training, and competence and my own skill, training, education and competence.

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TELEPHONE NUMBER

I \_\_\_\_\_, Physician Assistant, certify that I have reviewed this document with the above-named collaborating physician and have also reviewed the Statutes, Rules and Regulations that govern the practice of physician assistants in the State of Missouri.

\_\_\_\_\_  
PHYSICIAN ASSISTANT SIGNATURE

\_\_\_\_\_  
LICENSE NUMBER

\_\_\_\_\_  
DATE

### PHYSICIAN ASSISTANT CHANGE OF COLLABORATIVE PRACTICE

If this form indicates a change in collaborating physicians, please indicate your previous collaborating physician's name and license number.

\_\_\_\_\_  
PHYSICIAN NAME

\_\_\_\_\_  
PHYSICIAN LICENSE NUMBER

\_\_\_\_\_  
PHYSICIAN NAME

\_\_\_\_\_  
PHYSICIAN LICENSE NUMBER

\_\_\_\_\_  
PHYSICIAN NAME

\_\_\_\_\_  
PHYSICIAN LICENSE NUMBER