

**APPLICATION FOR REINSTATEMENT—PRESCRIPTIVE AUTHORITY  
ADVANCED PRACTICE NURSE**

**APPLICANT INSTRUCTIONS**

**Use this application to reinstate your expired Full Prescriptive Authority (RxN).  
If your Provisional Prescriptive Authority (RxN-P) expired due to either date or operation of law, you must re-apply  
using an Original Application for Prescriptive Authority.**

**Basic Requirements.** All applicants must hold an active, unencumbered Colorado Registered Nurse license **OR** an active, unencumbered Compact Multi-state Registered Nurse license and be listed on the Advanced Practice Registry in the same role and population(s) for which prescriptive authority is being requested. Other requirements are outlined in the Nurse Practice Act, specifically C.R.S. 12-38-111.6, and the Board's rules, specifically Chapter XV, both available at [www.dora.state.co.us/nursing/statutesrulespolicies.htm](http://www.dora.state.co.us/nursing/statutesrulespolicies.htm).

In compliance with the Michael Skolnik Medical Transparency Act of 2010, licensees are required to complete an online Healthcare Professions Profile on our website at [www.dora.state.co.us/hppp](http://www.dora.state.co.us/hppp).

**About the Application.** This application is to be completed by you and returned to the State Board of Nursing. All questions on the application are mandatory, and all supporting documentation and the appropriate fee must be received before the application is considered complete. You may copy as many forms as needed; however, each form submitted must be an original, completed in ink or typed. Keep a copy of the completed application for your records.

**Application Expiration.** Your application will be kept on file for one (1) year from date of receipt at the Board of Nursing. Your file and all supporting documentation will be purged if you do not submit required documents and complete the application process in one year. At that time, you will be required to submit a new, current application, all supporting documentation, and the current application fee.

**Social Security Number is Required.** Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit his/her Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. The affidavit is available on our website at [www.dora.state.co.us/registrations/SSNAffidavit.pdf](http://www.dora.state.co.us/registrations/SSNAffidavit.pdf), or you may call (303) 894-7800 to request that one be mailed to you.

**Disclosure of Addresses.** Consistent with Colorado law, all addresses and phone numbers on record with the Division are public record and must be provided to the public when requested. It is your responsibility to keep your address and contact information up-to-date in our database. All letters, renewal notices, and licenses are mailed to the last known address of record. If your address is not current, it is possible you will not receive important documents. You can change your address online by using Registrations Online Services at [www.doradls.state.co.us](http://www.doradls.state.co.us).

**Each Application Requires Its Own Documentation.** You must provide all documentation requested in these instructions even if you have submitted the same or similar documentation with previous applications. Each application must stand on its own merit. All supporting documentation must be provided by you, the applicant, and be attached to this application, unless otherwise noted.

**Note:** An Advanced Practice Nurse must apply for and be granted Prescriptive Authority before beginning to prescribe independently in Colorado. For inquiries regarding DEA numbers to prescribe controlled substances, contact the Drug Enforcement Administration at [www.deadiversion.usdoj.gov/drugreg/index.html](http://www.deadiversion.usdoj.gov/drugreg/index.html).

## APPLICANT CHECKLIST

### To reinstate your Full Prescriptive Authority (RxN) as an Advanced Practice Nurse (APN):

- Complete the attached application.** Return the completed application and all supporting documentation to the State Board of Nursing.  
  
You must **submit a separate Prescriptive Authority application and fee for each role or population focus** (e.g., for which you are seeking Prescriptive Authority).  
  
**Note:** your scope of practice as an Advanced Practice Nurse with Prescriptive Authority is determined by your education and preparation in the role and population(s) for which you are recognized on the Advanced Practice Registry. See the Board's Chapter XIV and Chapter XV rules at [www.dora.state.co.us/nursing/statutesrulespolicies.htm](http://www.dora.state.co.us/nursing/statutesrulespolicies.htm).
- Enclose the non-refundable application processing fee.** See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and **made payable to State of Colorado**. All fees are non-refundable and subject to change every July 1.
- Complete and return the attached Affidavit of Eligibility form.** Pursuant to C.R.S. 24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.
- Provide documentation of any name change.** If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).
- Request official verification of certification.**
  - Nurse Practitioner and Clinical Nurse Specialist: Request verification of certification from a nationally-recognized certifying body where you have been certified in the corresponding role and population focus for which you are applying.
  - Certified Nurse Midwife: Request verification of certification as a Certified Nurse Midwife from the certifying body, American Midwifery Certification Board (AMCB).
  - Certified Registered Nurse Anesthetist: Request a letter of verification of certification or recertification as a Certified Registered Nurse Anesthetist from the certifying body, American Association of Nurse Anesthetists (AANA).

Certifying bodies must send verifications directly to the Colorado State Board of Nursing, 1560 Broadway, Suite 1350, Denver, CO 80202; or directly by e-mail to [apauthorities@dora.state.co.us](mailto:apauthorities@dora.state.co.us).

  - **The State Board of Nursing will not initiate the request nor verify certification on your behalf.**
- Complete a Healthcare Professions Profile.** In compliance with the Michael Skolnik Medical Transparency Act of 2010, you are required to complete an online profile on our website at [www.dora.state.co.us/hppp](http://www.dora.state.co.us/hppp). You cannot start your profile until the Division of Registrations receives your application and enters it into our database. Allow 10 days from the date your application was mailed before accessing the website. If you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at [hppp@dora.state.co.us](mailto:hppp@dora.state.co.us) or (303) 894-5942.
- Submit the Attestation of Development of an Articulated Plan—Form RXN-B:**
  - Complete the Licensee Information section and Part I—Attestation—Advanced Practice Nurse with Prescriptive Authority.
  - Have a physician or a physician plus an advanced practice nurse with prescriptive authority complete Part II—Attestation—Physician or Physician and Advanced Practice Nurse with Prescriptive Authority.
  - **Only original signatures will be accepted.**

### If your Prescriptive Authority has been expired for more than two (2) years:

- Complete the Competency to Practice section of this application and submit required documentation.** You must demonstrate competency to practice and meet all current requirements for Prescriptive Authority.

If you have questions about the application, call (303) 894-2912.

**Return your completed application packet and all supporting documentation to:**

Division of Registrations  
State Board of Nursing—Advanced Practice Nursing  
1560 Broadway, Suite 1350  
Denver, CO 80202

**Colorado Department of Regulatory Agencies**  
 Division of Registrations  
 1560 Broadway, Suite 1350  
 Denver, CO 80202

**Licensee/Applicant Full Legal Name**

Last	First	Middle	Suffix

**Colorado Professional or Occupational License/Certification/Registration Number:** \_\_\_\_\_  
 (if already licensed)

**Professional or Occupational License/Certification/Registration type applying for:** \_\_\_\_\_

**AFFIDAVIT OF ELIGIBILITY**

Pursuant to H.B. 06S-1009, C.R.S. 24-34-107, ALL applicants for original licensure\* or licensees renewing or reinstating a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

*\*The word "licensure" is used as a general term. While most of the professions and occupations are licensed, others may be certified, registered, or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.*

**Section A: LAWFUL PRESENCE in the United States**

1.  I am a U.S. citizen. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
2.  I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
3.  I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)
  - a.  I am a U.S. citizen, not physically present or employed in the United States.
  - b.  I am a Foreign National, not physically present or employed in the United States.

**Section B: SECURE AND VERIFIABLE DOCUMENTS**  
 Select ONE document in this section if you checked 1 or 2 in Section A.

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
<input type="checkbox"/> Driver's license or permit				
<input type="checkbox"/> Government issued ID card				
<input type="checkbox"/> Valid U.S. military ID/common access card				
<input type="checkbox"/> Colorado Department of Corrections inmate ID				
<input type="checkbox"/> Tribal ID card				
<input type="checkbox"/> U.S. passport				
<input type="checkbox"/> Certificate of Naturalization				

**Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)**

<b>Government Issued Identification</b>	<b>Name of state agency or federal agency that issued the document</b>	<b>Full name as shown on driver's license or state/federal issued ID</b>	<b>License/ID Number</b>	<b>Expiration Date (mm/dd/yyyy)</b>	
<input type="checkbox"/> Certificate of (U.S.) Citizenship					
<input type="checkbox"/> Valid Temporary Resident card					
<input type="checkbox"/> Valid I-94 issued by Canadian government					
<input type="checkbox"/> Valid I-94 with refugee/asylum stamp					
<input type="checkbox"/> Valid I-766 (Employment Authorization Card)			<b>Issuing federal agency:</b>		
<b>Name on card</b>	<b>Alien Number (A#)</b>	<b>Card Number</b>	<b>Valid from (mm/dd/yyyy)</b>	<b>Expires (mm/dd/yyyy)</b>	
<input type="checkbox"/> Valid I-551 (Resident Alien or Permanent Resident Card)			<b>Issuing federal agency:</b>		
<b>Name on card</b>	<b>Alien Number (A#)</b>	<b>Country of birth</b>	<b>Card expires (mm/dd/yyyy)</b>	<b>Resident since (mm/dd/yyyy)</b>	
<input type="checkbox"/> Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94					
<b>Issuing foreign country</b>	<b>Passport Number</b>	<b>Visa Number</b>	<b>Visa Class (ex.: J-1, P-1, H-1B, etc.)</b>	<b>Date of entry (mm/dd/yyyy)</b>	<b>Until date (mm/dd/yyyy)</b>
<input type="checkbox"/> Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa					
<b>Issuing foreign country:</b>			<b>Passport Number:</b>		

**Section C: ATTESTATION**

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.
- I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

\_\_\_\_\_  
Print Full Legal Name

\_\_\_\_\_  
Signature (Full Name)

\_\_\_\_\_  
Date

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

Fees may be paid by check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*.

**PART 1—CURRENT LICENSE INFORMATION**

<b>RN License Number:</b>	<b>Issuing State:</b>	<b>Expiration Date:</b>
<b>Colorado Advanced Practice Registry Number:</b>	<b>Expiration Date:</b>	
<b>Colorado Prescriptive Authority Number:</b>	<b>Expiration Date:</b>	

**PART 2—APPLICANT INFORMATION**

<b>Name:</b> Last:	First:	Middle:	Suffix:
<b>Previous Name(s):</b>			
<b>Social Security Number:</b>	<b>Date of Birth</b> (mm/dd/yyyy):	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Place of Birth</b> (city and state, or foreign country):			
<b>Mailing Address:</b> This is a <input type="checkbox"/> Home <input type="checkbox"/> Business	PO Box, Street: City, State, Zip:		
<b>Daytime Telephone Number:</b> (     )	<b>E-mail Address:</b> Preferred method for communication: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail		

**PART 3—PRESCRIPTIVE AUTHORITY INFORMATION**

**Advanced Practice Role and Population Focus, if applicable, for which you are applying for Prescriptive Authority:**

Nurse Practitioner (NP)

Clinical Nurse Specialist (CNS)

*Population Focus for NP and CNS:*

Acute Care       Family       Neonatal       Psychiatric/Mental Health       Other: \_\_\_\_\_

Adult       Geriatric       Pediatric       Women's Health

Certified Nurse Midwife (CNM)

Certified Registered Nurse Anesthetist (CRNA)

**\*Social Security Number Disclosure:** Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's social security number. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support under § 14-14-113 and § 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation for identification purposes only. Your social security number will not be released for any other purpose not provided for by law.

**OFFICE USE ONLY** Prescriptive Authority Number: \_\_\_\_\_ Date Approved: \_\_\_\_\_

**PART 4—PRACTICE INFORMATION**

Since the date your Prescriptive Authority expired, have you prescribed independently in the state of Colorado?  YES  NO

**PART 5—DECLARATION OF PRIMARY STATE OF RESIDENCE**

“Primary state of residence” is defined as the state of a person’s declared fixed permanent and principal home for legal purposes; domicile. **You may be required to provide proof of residency.**

I declare that the state of \_\_\_\_\_ is my primary state of residence and that such constitutes my permanent and principal home for legal purposes.

**Note:** If you declare Colorado as your primary residence, you must obtain, reactivate, or reinstate a Colorado RN license prior to applying for the Advanced Practice Registry or Prescriptive Authority.

Primary Residence Physical Address:	Street:  City, State, Zip:
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**PART 6—NATIONAL CERTIFICATION**

**Verification of Certification:** Request that verification of your current certification be sent directly to: Colorado State Board of Nursing, 1560 Broadway, Suite 1350, Denver CO 80202, **OR** directly by e-mail to [apauthorities@dora.state.co.us](mailto:apauthorities@dora.state.co.us).

Certifying Agency	Certification Date	Expiration Date	Number

**PART 7—COMPETENCY TO PRACTICE**

**Has your Prescriptive Authority been expired more than two (2) years?**

- NO.** Your application is complete. Sign, date, and submit your application to the State Board of Nursing.
- YES.** Demonstrate competency and compliance with current criteria as follows:

**VERIFICATION OF EDUCATIONAL CRITERIA:** Request that official transcripts reflecting your conferred degree be issued to you in a sealed envelope. The transcripts must be submitted with your application. **DO NOT REQUEST THAT TRANSCRIPTS BE SENT TO THE BOARD OF NURSING UNLESS SPECIFICALLY INSTRUCTED TO DO SO BY BOARD STAFF.**

**Transcripts must verify either:**

- A graduate degree or higher as an Advanced Practice Nurse in the population focus selected; **OR**
- A graduate degree in nursing and a post-graduate degree or post-graduate certificate as an Advanced Practice Nurse in the population(s) selected. Submit one transcript for your graduate degree in nursing and one transcript for your post-graduate degree or post-graduate certificate in your designated population focus if you did not complete your degrees/certificates at the same educational institution.

**PART 7—COMPETENCY TO PRACTICE (Continued)**

**IF YOUR PRESCRIPTIVE AUTHORITY HAS BEEN EXPIRED MORE THAN TWO (2) YEARS (CONTINUED):**

**Program from which you obtained your Advanced Practice graduate degree, post-graduate degree, or post-graduate certificate:**

Name of Program and Institution (e.g., FNP at University of Colorado)	Location (city and state)	Focus	Degree Awarded	Year Completed

**Population Focus:**     *Acute Care*     *Family*     *Neonatal*     *Psychiatric/Mental Health*     *Other: \_\_\_\_\_*  
 *Adult*     *Geriatric*     *Pediatric*     *Women's Health*

**Program from which you obtained your graduate degree in nursing (if different from above):**

Name of Program and Institution (e.g., MSN at University of Colorado)	Location (city and state)	Focus	Degree Awarded	Year Completed

**REQUIRED COURSEWORK:** List the graduate-level courses that meet the requirement for completion of three (3) semester credit hours or four (4) quarter credit hours for each category (assessment, pathophysiology, and pharmacology) below. Provide copies of course descriptions or course syllabi when the required coursework is integrated into broad categories of advanced practice courses or when course titles do not accurately reflect course content. Letters of verification are not accepted. If needed, attach an additional sheet in the same format.

**Advanced Health/Physical and Psychological Assessment:**

Course Name and Number	Hours

**Advanced Pathophysiology/Psychopathology:**

Course Name and Number	Hours

**Advanced Pharmacology:**

Course Name and Number	Hours

**ATTESTATION**

In accordance with sections 18-8-503 and 18-8-501(2)(a)(I), Colorado Revised Statutes, false statements made herein are punishable by law. I understand that under the Nurse Practice Act, providing false information to the Board is grounds for denial, suspension or revocation of a Registered Nurse license.

I state under penalty of perjury, as defined in C.R.S. 18-8-503, that the information contained in this application is true and correct to the best of my knowledge.

\_\_\_\_\_  
**Signature of Applicant** (must be original signature)

\_\_\_\_\_  
**Date**

**ATTESTATION OF DEVELOPMENT OF ARTICULATED PLAN—FORM RXN-B**

**APPLICANT:** Submit this form if your Prescriptive Authority was awarded after 7/1/2010 OR if you are applying for Prescriptive Authority to document completion of development of an articulated plan.

Return the completed form to: State Board of Nursing, 1560 Broadway, Suite 1350, Denver, CO 80202

**LICENSEE INFORMATION**

<b>Name: Last:</b>	<b>First:</b>	<b>Middle:</b>	<b>Suffix:</b>
<b>Mailing Address:</b> <i>This is a <input type="checkbox"/> Home <input type="checkbox"/> Business</i>		PO Box, Street: City, State, Zip:	
<b>Daytime Telephone Number:</b> (     )		<b>E-mail Address:</b> <i>Preferred method for communication: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail</i>	
<b>RN License Number:</b>	<b>Advanced Practice Authority Number(s) :</b>	<b>Prescriptive Authority Number(s):</b> <i>(if applicable)</i>	

**PART I—ATTESTATION—ADVANCED PRACTICE NURSE WITH PRESCRIPTIVE AUTHORITY**

The Nurse Practice Act and the Colorado State Board of Nursing Chapter XV Rules require that Advanced Practice Nurses requesting Full Prescriptive Authority (RXN) develop an articulated plan for safe prescribing that documents how the advanced practice nurse intends to maintain ongoing collaboration with physicians and other health care professionals in connection with the advanced practice nurse’s practice of prescribing medication within his or her role and population focus.

The Articulated Plan shall be retained by the RXN, shall be reviewed annually and appropriately updated, and shall be available to the State Board of Nursing upon request.

**I state under penalty of perjury, as defined in C.R.S. 18-8-503, that by signing this Attestation, I have developed an articulated plan in compliance with the requirements of C.R.S. 12-38-111.6(4.5)(b)(II) and the State Board of Nursing Chapter XV Rules.**

\_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date**

**PART II—ATTESTATION—PHYSICIAN or PHYSICIAN AND ADVANCED PRACTICE NURSE WITH PRESCRIPTIVE AUTHORITY**

The development of the initial articulated plan may be attested to by a physician or an Advanced Practice Nurse with Prescriptive Authority (RXN).

**I state under penalty of perjury, as defined in C.R.S. 18-8-503, that by signing this Attestation I assisted in the development of the initial articulated plan for the above-named Advanced Practice Nurse in compliance with the requirements of C.R.S. 12-36-106.4(2) and State Medical Board Rule 950.**

\_\_\_\_\_  
**Physician Signature** \_\_\_\_\_  
**License Number** \_\_\_\_\_  
**Date**

**I state under penalty of perjury, as defined in C.R.S. 18-8-503, that by signing this Attestation I assisted in the development of the initial articulated plan for the above-named Advanced Practice Nurse in compliance with the requirements of C.R.S. 12-38-111.6 and State Board of Nursing Chapter XV Rules.**

\_\_\_\_\_  
**RXN Signature (if applicable)** \_\_\_\_\_  
**License Number** \_\_\_\_\_  
**Date**