

**ANP/FNP/CNS/CNM Addendum to the Texas Standard Credentialing Application**  
**(Must be completed, signed and returned)**

PROVIDER NAME: \_\_\_\_\_ DEGREE: \_\_\_\_\_

PHONE # \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

**DEFINITIONS:**

**Advanced Practice Nurse**—A registered nurse approved by the board to practice as an advanced practice nurse based on completing an advanced educational program acceptable to the board. The term includes a nurse practitioner, nurse-midwife, nurse anesthetist, and a clinical nurse specialist. The advanced practice nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings including but not limited to homes, hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. The advanced practice nurse acts independently and/or in collaboration with other health care professionals in the delivery of health care services

**Carrying out or signing a prescription drug order**—completing a prescription drug order pre-signed by the delegating physician or signing (writing) a prescription by an advanced practice nurse after that person has been designated to the Board of Medical Examiners by the delegating physician as a person delegated to sign a prescription.

**Controlled Substance**—A substance, including a drug, an adulterant, and a dilutant, listed in Schedules I through V or Penalty Groups 1, 1-A, or 2 through 4 of chapter 481 Texas Health and Safety Code (Texas Controlled Substances Act). The term includes the aggregate weight of any mixture, solution, or other substance containing a controlled substance.

**Dangerous Drug**—A device or a drug that is unsafe for self-medication and that is not included in schedules I-V of chapter 481 Texas Health and Safety Code (Texas controlled Substances Act). The term includes a device or a drug that bears or is required to bear the legend: "Caution: federal law prohibits dispensing without a prescription" or "RX only" or another legend that complies with federal law.

**Protocols or other written authorization**—Written authorization to provide medical aspects of patient care which are agreed upon and signed by the advanced practice nurse and the physician, reviewed and signed at least annually, and maintained in the practice setting of the advanced practice nurse. Protocols or other written authorization shall be defined to promote the exercise of professional judgment by the advanced practice nurse commensurate with his/her education and experience. Such protocols or other written authorization need not describe the exact steps that the advanced practice nurse must take with respect to each specific condition, disease, or symptom and may state types or categories of drugs which may be prescribed rather than just list specific drugs.

**PRESCRIBING AUTHORITY:**

\_\_\_\_\_ YES      \_\_\_\_\_ NO      Have you (applicant) been approved by the Texas Board of Nurse Examiners (BNE) to carry out or sign prescription drug orders and been issued a prescription authorization number?

Advanced Practice Nurses approved by the BNE with valid prescription authorization numbers are eligible to carry out and/or sign prescription drugs for **dangerous drugs** in accordance with the standards and requirements set forth by the BNE.

**Prescription Authorization Number:** \_\_\_\_\_

\_\_\_\_\_ YES      \_\_\_\_\_ NO      Do you plan to prescribe **Controlled Substances** (drugs listed in Schedules III, IV, or V)?  
*Advanced Practice Nurses with full authorization to practice and valid prescription authorization numbers are eligible to prescribe certain categories of controlled substances and must comply with all federal, state and local laws and regulations relating to the prescribing of controlled substances, including but not limited to, requirements set forth by the Texas Department of Public Safety and the Drug Enforcement Administration.*

\_\_\_\_\_ YES      \_\_\_\_\_ NO      Do you possess DEA (Federal Controlled Substance) and DPS (TX Department of Safety Controlled Substance) Permits/Certificates? *(Please attach copies of certificates)*

If Yes,      DEA# \_\_\_\_\_      Expiration \_\_\_\_\_

                    DPS# \_\_\_\_\_      Expiration \_\_\_\_\_

**PROTOCOLS/WRITTEN AUTHORIZATION:**

\_\_\_\_\_ YES      \_\_\_\_\_ NO      In my current position with (delegate), I have reviewed, understood, agreed upon and signed along with my Supervising Physician, protocols or other written authorization which defines my duties and role as an Advanced Practice Nurse in a manner that promotes professional judgment commensurate with my education and experience. Acts that may be delegated include: administering, providing, carrying out, or signing a prescription drug order as authorized through physician's orders, standing medical orders, standing delegation orders, or other protocols as defined by the board. Providing and carrying out or signing a prescription drug order under this subdivision is limited to dangerous drugs and controlled substances (schedules III-V) and shall comply with other applicable laws. *(Please attach a copy of signed/dated protocol/written authorization)*

**SUPERVISING PHYSICIAN INFORMATION:**

\_\_\_\_\_ YES      \_\_\_\_\_ NO

**I WILL** administer, dispense or prescribe dangerous drugs or controlled substances (Schedules III, IV, and V) and comply with the requirements for adequate physician supervision published by the TMB as well as other applicable state laws.

*The advanced practice nurse with a valid prescription authorization number shall carry out or sign prescription drug orders for only those drugs that are authorized by Protocols or other written authorization for medical aspects of patient care and prescribe for patient populations within the accepted scope of professional practice of the SPN's specialty area and under the supervision of the assigned supervising physician. The physician must provide continuous supervision, but the constant physical presence is not required.*

Supervising Physician Name: \_\_\_\_\_

Physician TMB License # \_\_\_\_\_ Expiration \_\_\_\_\_

DEA # \_\_\_\_\_ Expiration \_\_\_\_\_

DPS # \_\_\_\_\_ Expiration \_\_\_\_\_

I certify the information provided by me on this document is true, correct and complete to the best of my knowledge and belief. I understand and agree that any misstatement or omission of information concerning administering, dispensing or the prescribing of controlled substances may constitute grounds for withdrawal of the application for consideration.

Providers Signature \_\_\_\_\_ Date \_\_\_\_\_

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