



ARNP Prescriptive Authority Application for *already* licensed ARNP's

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number, please read, complete, and return this [form](#) with your application.

This disclosure is mandatory, based on section 466(a)(13) of the Social Security Act [42 U.S.C. 666(a)(13)], and will be used under the State's child support enforcement program to locate individuals for the purposes of establishing paternity and establishing, modifying, and enforcing support obligations.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted for a social security number.

In order to process your request:

Mail your application with your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send supporting documents not mailed with your application to:

Nursing Commission
P.O. Box 47864
Olympia, WA 98504-7864

Contact us

Phone: 360-236-4703

E-mail:

NurseLicensing@doh.wa.gov

Note: If you already have an active Washington State ARNP license and you are adding prescriptive authority, no fee is required.

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Nursing Laws, RCW 18.79](#)

[Nursing Rules, WAC 246-840](#)



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Date Stamp Here

Revenue 0258010000

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If we do not receive all required documentation within 30 days your application may be closed as incomplete resulting in you having to reapply and pay the application fee again.

1. Demographic Information

- Male
- Female
- Other

Social Security Number (SSN) :
(If you do not have a SSN, see instructions)

Name (First, Middle, Last):

Birth date:

E-mail address:

Address:

City:

State:

Country:

ZIP code:

Phone number:

County:

Note: The mailing and e-mail addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the Nursing Commission.

Have you ever been known under any other name(s)?
If yes, list name(s):

Yes No

Will documents be received in another name?
If yes, list name(s):

Yes No

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Review for: FBI NPDB/NURSYS WSP PDQ NOD

Approved per policy A21.07 delegated decision making for selected license applications

Forward to CMT Approved by CMT Denied by CMT

Proceed with licensing process _____

Signature

Date

2. Personal Data	Yes	No
<p>1. Do you have a medical condition which impairs or limits your ability to practice your profession with reasonable skill and safety?</p> <p style="text-align: right;"> <input type="checkbox"/> <input type="checkbox"/> </p> <p>If you answered yes to question 1, explain:</p> <p>a. How your treatment has reduced or eliminated the limitations caused by your medical condition.</p> <p>b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.</p>		
<p>Note: If you answered “Yes” to question 1, the Nursing Commission will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued. The Nursing Commission may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the Nursing Commission. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the Nursing Commission, your application may be denied.</p>		
<p>2. Do you currently use chemical substance(s) which impair or limit your ability to practice your profession with reasonable skill and safety?</p> <p style="text-align: right;"> <input type="checkbox"/> <input type="checkbox"/> </p> <p>“Currently” means within the past two years.</p> <p>“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.</p>		
<p>3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?</p> <p style="text-align: right;"> <input type="checkbox"/> <input type="checkbox"/> </p>		
<p>4. Are you currently engaged in the illegal use of controlled substances?</p> <p style="text-align: right;"> <input type="checkbox"/> <input type="checkbox"/> </p> <p>“Currently” means within the past two years.</p> <p>“Illegal use of controlled substances” is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.</p>		
<p>Note: If you answer “Yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. If you do not provide the documents, your application is incomplete and will not be considered. To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied. The department does criminal background checks on all applicants.</p>		
<p>5. Have you ever:</p> <p>a. Been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?</p> <p style="text-align: right;"> <input type="checkbox"/> <input type="checkbox"/> </p> <p>b. Been charged with a crime and are currently facing potential prosecution in any state or jurisdiction?</p> <p style="text-align: right;"> <input type="checkbox"/> <input type="checkbox"/> </p> <p>c. Been made aware that you are a current suspect or under investigation in any state or jurisdiction that has not yet been completely resolved?</p> <p style="text-align: right;"> <input type="checkbox"/> <input type="checkbox"/> </p>		

2. Personal Data Questions (cont.)	Yes	No
6. Are you under current investigation, currently charged, or have you ever been found in any civil, administrative, or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	<input type="checkbox"/>	<input type="checkbox"/>
b. Diverted controlled substances or legend drugs?	<input type="checkbox"/>	<input type="checkbox"/>
c. Violated any drug law?	<input type="checkbox"/>	<input type="checkbox"/>
d. Prescribed controlled substances for yourself?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever:		
a. Been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been charged with or accused of violating any state or federal law or rule regulating the practice of a health care profession?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been made aware that you are under current investigation in any state or jurisdiction for violating any state or federal law or rule regulating the practice of a health care profession?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had any license, certificate, registration, or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	<input type="checkbox"/>	<input type="checkbox"/>

3. Pharmacology Education for Prescriptive Authority

<input type="checkbox"/> I graduated within the past two years and completed an advanced pharmacology course.
<input type="checkbox"/> I have attached 30 hours of continuing education in pharmacology completed within the past two years. Evidence must show pharmacology hours earned. (form)

4. Prescriptive Authority Requirement
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<input type="checkbox"/> I certify I have read the 2018 rules that govern the use of opioids for treatment of chronic non-cancer pain. See WAC 246-840-460 to 246-840-4990 .
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5. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)

Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Nursing Commission may require more information before deciding on my application. The Nursing Commission may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the Nursing Commission of any past, current or future criminal charges or convictions. I will also inform the Nursing Commission of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the Nursing Commission information on my health, including mental health and any substance abuse treatment.

By: _____ Dated _____
(Original signature of applicant) (mm/dd/yyyy)