



ALASKA BOARD OF NURSING
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
550 WEST 7TH AVENUE, SUITE 1500
ANCHORAGE, ALASKA 99501
Telephone: (907) 269-8161 Fax: (907) 269-8196
E-mail: license@alaska.gov
Website: www.nursing.alaska.gov

ADVANCED NURSE PRACTITIONER APPLICATION

If you received this application other than directly from the Division or its official website, the application may be outdated or not an official version. To ensure you have the official version, please contact the Division.

To practice as an Advanced Nurse Practitioner, or to use the title in the State of Alaska, a person must be authorized to do so by the Board of Nursing (12 AAC 44.400). **Individuals must hold a current Alaska RN license to be eligible for an ANP or CRNA authorization.** Advanced Nurse Practitioner is defined by statute as "a registered nurse authorized to practice in the state who, because of specialized education and experience, is certified to perform acts of medical diagnosis and the prescription and dispensing of medical, therapeutic, or corrective measures under regulations adopted by the board" (AS 08.68.410(1)).

RECOGNIZED CERTIFICATION BODIES

If you were certified by a body not recognized by the board, you must provide the board with sufficient data to evaluate the authority of that body; i.e., who accredited the program, who developed and administered the certifying/qualifying examination, what criteria was used for program approval such as goals, organization administration, curriculum, length of program, faculty qualifications, resources, and evaluation processes. (See enclosed list of approved certification programs.)

SCOPE OF PRACTICE

The Scope of Practice statement published by the certifying body will determine the limits of the ANP's practice.

APPLICATION PROCEDURES (Pursuant to 12 AAC 44.400)

The following must be submitted before your application can be reviewed:

1. A completed application signed and notarized.
2. Check or money order made payable to the State of Alaska (see application for fee schedule).
3. Certified transcript sent to the Board directly from the school of nursing evidencing successful completion of a course of study in accordance with 12 AAC 44.400 (a)(1)(A).
4. Certified true copy of a current certificate in a specialty area by a national certifying body. In the absence of a continuing education requirement of the certifying body, you must submit proof (copies of certificates, etc.) of receiving 30 contact hours, within the past two years, of continuing education in the specialty area for which you are applying.
5. Consultation and Referral Plan (form enclosed).
6. Reference form (enclosed) completed by one of the three references listed on your application.
7. Certified true copy of current advanced nurse practitioner license in another state or jurisdiction (if applying for a temporary permit and currently licensed in another state or jurisdiction.)
8. For Prescriptive Authority: Pursuant to 12 AAC 44.440, you must submit copies of certificates of completion of 15 contact hours of education in advanced pharmacology and clinical management of drug therapy obtained within the past two years. Include a course outline or any other documentation indicating actual hours of pharmacology.

TEMPORARY NURSE PRACTITIONER PERMIT (Pursuant to 12 AAC 44.450):

A non-renewable, temporary permit may be issued to an applicant who holds a current license to practice as a registered nurse in Alaska and is either currently certified as an advanced nurse practitioner in another state or jurisdiction, has been accepted to take the next specialty board examination, or is awaiting certification results.

Applicants currently certified as an ANP in another state or jurisdiction must comply with items 1-3 and 5-7 (and 8, if applicable) listed above.

Applicants scheduled to take the next specialty board examination or awaiting certification results must comply with items 1-3 and 5-6 (and 8, applicable) listed above and submit a copy of the exam approval scheduling letter from the national certifying body which includes the date of examination.

TO PRESCRIBE AND DISPENSE SCHEDULE 2-5 CONTROLLED SUBSTANCES (Pursuant to 12 AAC 44.445):

1. Submit the "Advanced Nurse Practitioner Application Authorization to Prescribe and Dispense Controlled Substances" along with \$50.00 made payable to the State of Alaska.
2. Application must reflect one year of experience while licensed as an ANP prescribing legend drugs under 12 AAC 44.440 within the past five years.

Please be aware that you must also apply for registration with the Federal Drug Enforcement Agency.

Registration applications are available from the DEA at 400 Second Avenue West, Seattle, WA 98119, (888) 219-1418. Prescriptions must be signed by the prescriber with the initial "ANP," the prescriber's identification number assigned by the board and the prescriber's DEA number.

Note: Adult or Family Psychiatric Mental Health Nurse Practitioners:

An applicant for an authorization to practice as an adult or family psychiatric mental health nurse practitioner must submit:

- (1) certification issued by the American Nurses Credentialing Center before January 1, 2003 certifying that the applicant has passed the examination administered by the American Nurses Credentialing Center for:
(A) psychiatric mental health clinical nurse specialist; or
(B) adult or family psychiatric mental health practitioner; **or**
- (2) certification issued by the American Nurses Credentialing Center on or after January 1, 2003 certifying that the applicant has passed the examination administered by the American Nurses Credentialing Center for adult or family psychiatric mental health nurse practitioner.

APPLICATION PROCESS

Applications are processed in the date of order received. Please allow six to eight weeks for the processing of properly completed applications. You will be notified, in writing, of application deficiencies or application approval.

If you hold current authorization as an Alaska Advanced Nurse Practitioner and wish to add prescriptive authority, please complete the application and provide proof of the required pharmacology and the prescriptive authority fee of \$50.00.

Please be aware that the denial of an application for licensure may be reported to any person, professional licensing board, federal, state or local government agency, or other entity making a relevant inquiry or as may be required by law.

RENEWAL INFORMATION

All registered nurse and advanced nurse practitioner licenses **lapse on November 30 of even-numbered years** regardless of when first issued, except new licenses issued within 90 days of the expiration date will be issued a valid license through the next biennium. An ANP license will not be renewed until the licensee's RN license has been renewed.

You MUST maintain national certification and hold current certification to renew your ANP authorization along with completing applicable continuing education.

A renewal notice will be mailed at least 60 days before the license expiration date. Failure to receive a renewal notice does not relieve a licensee of the responsibility to renew by November 30.

BUSINESS LICENSE INFORMATION

All professional license holders, including nurses, who are conducting business or offering services in Alaska and who are not considered an employee, must hold a business license. Please contact the Division of Corporations, Business and Professional Licensing at (907) 465-2550 for more information.

"Certified True Copy" means a copy of a document that includes a statement of certification, signed under penalty of unsworn falsification before a notary public that the document is a true copy of the original document.



ALASKA BOARD OF NURSING
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
550 WEST 7TH AVENUE, SUITE 1500
ANCHORAGE, ALASKA 99501
Telephone: (907) 269-8161 Fax: (907) 269-8196
E-mail: license@alaska.gov
Website: www.nursing.alaska.gov

ADVANCED NURSE PRACTITIONER AUTHORIZATION APPLICATION

- \$50.00 **Non-refundable Application Fee**
- \$75.00 **ANP Authorization Fee**
- \$50.00 **Prescriptive Authority Fee**
- \$50.00 **Controlled Substances Prescriptive Authority Fee**
- \$50.00 **Temporary Permit**

Make check or money order payable to the State of Alaska.

Alaska RN No.: _____ Alaska ANP No.: _____ Application in Progress

1. Name: _____
Last First MI Maiden

2. Mailing Address: _____
Street Address or P.O. Box City State Zip Code

3. Social Security No.: _____ Date of Birth: _____ Daytime Telephone No. _____
Required by AS 08.01.060. (If you are a foreign citizen unable to obtain a U.S. Social Security Number, contact the division for further instructions.)

E-mail Address: _____
(Please complete if you prefer to be notified of initial application status via e-mail.)

4. NURSE PRACTITIONER PROGRAM

Didactic Program: _____ From: _____ To: _____

Preceptorship Served Under: _____

5. Do you hold National certification: YES NO Date of original certification: _____

Name of certifying body: _____

If you are not certified, have you been accepted to take the next exam? YES NO

To be administered by: _____ Date: _____
(Provide a copy of the exam approval scheduling letter)

6. AREA OF SPECIALTY PRACTICE

Check The Appropriate Box:

- | | | |
|---|--|---|
| <input type="checkbox"/> Acute Care/Emergency | <input type="checkbox"/> Neonatal | <input type="checkbox"/> Family Psychiatric/Mental Health |
| <input type="checkbox"/> Adult Health | <input type="checkbox"/> Nurse Midwife | <input type="checkbox"/> Women's Health/OB-GYN |
| <input type="checkbox"/> Family Health | <input type="checkbox"/> Pediatric | |
| <input type="checkbox"/> Gerontological | <input type="checkbox"/> Adult Psychiatric/Mental Health | |

7. ADVANCED NURSE PRACTITIONER EXPERIENCE

Employer Name/Address	Location	Summary of Scope of Practice	Dates	
			From	To

8. PRESCRIPTIVE AUTHORITY FOR LEGEND DRUGS – 12 AAC 44.440

Do you want prescriptive/dispensing authority? YES NO

If you plan to dispense drugs, do you know the name of the pharmacist or pharmacy? Please indicate:

9. Pharmacology and clinical management of drug therapy education: List in chronological order 15 hours of education obtained during the past two years and submit copies of the certificates of attendance. **If the course was not specifically a pharmacology course include an outline of the course which identifies the section relevant to pharmacology.** Practitioners who are recent graduates may use a copy of their transcript, which shows a pharmacology course **in the last two years** or may submit a letter from the school indicating how you met the requirements.

Course Title/Content	Contact Hours/Academic Credit	Date(s)

10. List names and complete mailing addresses of three professional references. (Send the enclosed form to one of the references listed):

Name	Address
1.	
2.	
3.	

Applications without the appropriate attachments will be considered incomplete and will not be processed. All information supplied with this application will be considered "public" information unless required to remain confidential by law. Information about current licensees, including mailing addresses, is available from the Division's website at: www.commerce.state.ak.us/occ/ under "License Search."

I hereby certify that the information provided in this application is true and correct to the best of my knowledge. I understand that any false or misleading information in this application and accompanying documents may result in failure to obtain authorization or subsequent revocation of my authorization to practice as an Advanced Nurse Practitioner.

SIGN HERE 
In front of a notary

Signature of Applicant

SUBSCRIBED AND SWORN before me this _____ day of _____, 20____.

SIGN HERE 

Signature of Notary Public

Notary Public in and for the State of _____

My Commission Expires: _____

NOTARY SEAL

CONSULTATION PLAN AND REFERRAL GUIDELINES

Listed below are the guidelines for completing the outline for consultation and referral plan. In accordance with 12 AAC 44.400 (a)(5), an Advanced Nurse Practitioner, when delivering health care services to the public, shall have in effect a written plan that is **kept current** and made available to the board at any time the board considers it necessary for good cause; the plan must

- (A) conform to criteria established by the board;
- (B) include a method for quality assurance; and
- (C) be kept current and made available to the board at any time the board considers it necessary and for good cause.

Note: See Regulation 12 AAC 44.400

DESCRIPTION OF CLINICAL PRACTICE

Give a brief description of your clinical practice. Include a statement which indicates the general category of clients you expect to see on a routine basis and the focus of care you will be offering.

The category of client specified and focus of care in your clinical practice must be within the scope of practice of the ANP. The statement should be clear and concise. **THE FOLLOWING ARE GIVEN TO SERVE AS EXAMPLES ONLY:**

- a. The Certified Nurse Midwife will offer reproductive health care for women. The focus of practice will be the diagnosis and management of normal pregnancies and the management of normal deliveries in the acute care setting.
- b. The Adult Nurse Practitioner will offer ambulatory nursing care of adults, well care only. The focus of practice will be the diagnosis, treatment, and prevention of common GYN complaints.
- c. The Women's Health Care Nurse Practitioner will offer ambulatory nursing care for women. The focus of practice will be the diagnosis, treatment, and prevention of common GYN complaints.
- d. The Family Nurse Practitioner will offer ambulatory nursing care for families. The focus of practice will be in health education and medical diagnosis and treatment of common acute and common chronic illness.

CONSULTATION AND REFERRAL

- 1. List your method of routine consultations and referrals, including how these will be documented in the patient record. Include the names and titles of health care providers you will utilize. (No more than five are necessary.) PLEASE NOTE: if your practice includes medical diagnosis and treatment, you must have at least one physician on the consultation/referral list that is appropriate to your focus of practice.
- 2. List your method for emergency referrals which includes the names and contact information for physicians, clinics, hospitals, paramedics, etc., to be used in case of emergency.

QUALITY ASSURANCE

- 1. Describe the process for quality assurance you will use to evaluate your practice. The process must include the following elements:
 - a. use of standards which apply to your areas of practice;
 - b. concurrent or retrospective review of practice;
 - c. use of pre-established criteria; and
 - d. written evaluation of review with a plan for corrective action if indicated and follow-up.
- 2. Review should focus on area of practice where patient care problems are suspected or have been identified.

IT IS THE RESPONSIBILITY OF THE ANP TO KEEP THE CONSULTATION AND REFERRAL PLAN UP TO DATE AND IN CONFORMANCE WITH THE BOARD'S CRITERIA. FAILURE TO DO SO MAY RESULT IN REVOCATION OF AUTHORITY TO PRACTICE AS AN ANP.



ALASKA BOARD OF NURSING
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
550 WEST 7TH AVENUE, SUITE 1500
ANCHORAGE, ALASKA 99501
Telephone: (907) 269-8161 Fax: (907) 269-8196
E-mail: license@alaska.gov
Website: www.nursing.alaska.gov

ADVANCED NURSE PRACTITIONER REFERENCE FORM

APPLICANT: Please complete this section.

Name of Advanced Nurse Practitioner: _____
Last First MI

Dates of Association with Reference: _____

REFERENCE: Please complete the following information on behalf of the above-named applicant.

1. How often and in what capacity have you observed the applicant in the practice of an Advanced Nurse Practitioner?

2. Please give your rating of applicant's competence:

Excellent Good Fair Poor

3. Do you recommend this applicant for authorization as an Advanced Nurse Practitioner: YES NO

4. Please provide a statement regarding the applicant's ability to practice as an Advanced Nurse Practitioner.

Signature: _____ Date: _____

Name: _____ (Please print clearly)

Title: _____

Agency: _____

Mailing Address _____ Telephone: _____

PLEASE MAIL COMPLETED FORM DIRECTLY TO THE ADDRESS AT THE TOP OF THE PAGE.

FAXED COPIES ARE ACCEPTABLE (PLEASE SEND THE HARD COPY AS WELL)

ALASKA BOARD OF NURSING
ADVANCED PRACTICE CERTIFICATION PROGRAMS

Approved Certification Programs for Advanced Nurse Practitioners:

- 1. Council on Certification of Nurse Anesthetists (CCNA)**
 - Nurse Anesthetists
- 2. National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)**
 - Woman's Health Care Nurse Practitioner (formerly OB/GYN Nurse Practitioner)
 - Neonatal Nurse Practitioner
- 3. The National Certification Board of Pediatric Nurse Practitioners & Nurses (NCBPNP/N)**
 - Pediatric Nurse Practitioner
- 4. American Midwifery Certification Board (AMCB)**
 - Nurse Midwives
- 5. American College of Nurse Midwives (ACNM)**
 - Nurse Midwives
- 6. American Nurses Credentialing Center (ANCC)**
 - Adult Nurse Practitioner
 - Family Nurse Practitioner
 - Pediatric Nurse Practitioner
 - Gerontological Nurse Practitioner
 - Acute Care Nurse Practitioner
 - Adult Psychiatric/Mental Health Nurse Practitioner
 - Family Psychiatric/Mental Health Nurse Practitioner
- 7. American Academy of Nursing Practitioners (AANP)**
 - Family Nursing Practitioner
 - Adult Nurse Practitioner
 - Gerontological Nurse Practitioner

Note: Clinical Nurse Specialists are not eligible for authorization as Advanced Nurse Practitioners in the state of Alaska.