NUR

FOR OFFICE USE ONLY

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
E-mail: license@alaska.gov
Website: www.nursing.alaska.gov

ADVANCED NURSE PRACTITIONER APPLICATION FOR AUTHORIZATION TO PRESCRIBE AND DISPENSE CONTROLLED SUBSTANCES

☐ **$50.00 Nonrefundable Application Fee** (Make check or money order payable to the State of Alaska.)

In addition to the legend drug prescriptive authority authorized in 12 AAC 44.440, the board will, in this discretion, authorize an Advanced Nurse Practitioner to prescribe and dispense Schedule 2 –5 controlled substances in accordance with the applicable state and federal laws (12 AAC 44.445).

You must have the equivalent of one year of experience prescribing legend drugs after licensure within five years prior to this application.

1. Name: _____
   Last First M.I.
2. Mailing Address: _____
   _____ Telephone No.: _____
3. Business Address: _____
   _____
4. Alaska ANP Number: _____
5. Date of Birth: _____
6. Social Security Number: _____ Required by AS 08.01.060. (The department is not authorized to issue a license, unless the applicant's Social Security Number has been provided.)
7. ANP Prescribing Experience:

   Briefly describe your experience prescribing drugs during the past five years. Include the period of time you have been actively prescribing and the types of drugs.

   _____
   _____
   _____

I hereby certify that this information is true and correct to the best of my knowledge. I understand that any false or misleading information is this application or 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

SEAL

Notary Public in and for the State of _____

My Commission Expires: _____