IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is guilty of a Class A misdemeanor.	**Notice of Delegated Prescriptive Authority for Controlled Substances (Advanced Practice Registered Nurse) ADDING A DELEGATING PHYSICIAN**	**APRN-CS ADD Physician**

Do NOT complete this form if you are applying for initial licensure or if you are removing a delegating physician.

This form must be completed by the collaborating physician and is required WHEN ADDING A DELEGATING PHYSICIAN to an existing Advanced Practice Registered Nurse (APRN) Mid-Level Practitioner Controlled Substance License.

Email completed form to: *fpr.nurseunit@illinois.gov*

Removing a Delegating Physician:
If you are removing a delegating physician, please complete the *Notice of Termination of Supervision and/or Delegated Authority (Advanced Practice Registered Nurse & Physician Assistant)* form.

Initial Licensure:
If you are applying for a controlled substance license, please submit the *APRN-CS Initial Application* form along with your controlled substance license application. This form serves as official notice that you are authorizing the Advanced Practice Registered Nurse to prescribe controlled substances.

1. NAME OF ADVANCED PRACTICE REGISTERED NURSE (Last, First, Middle Initial)	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SSN OR ITIN __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. **Advanced Practice Registered Nurse Mid-level Practitioner Controlled Substances License** (Profession Name) **3 0 9** (Profession Code) 6. LICENSE NUMBER OF ADVANCED PRACTICE REGISTERED NURSE (If unknown, leave blank.) 209 _____	
7. MAIDEN OR GIVEN SURNAME	8. ADVANCED PRACTICE REGISTERED NURSE CONTROLLED SUBSTANCE NUMBER 309 _____	

This is to certify that I, _____, have delegated
(Collaborating Physician)

prescriptive authority to_____ in order to prescribe and/or
(Advanced Practice Registered Nurse)

dispense controlled substances categorized as Schedule II, III, IV, or V controlled substances, as defined in Article II of the Illinois Controlled Substances Act. I further certify the delegation of prescriptive authority is appropriate to my practice and within the scope of the advanced practice registered nurse's training. The advanced practice registered nurse named hereinabove may prescribe and/or dispense (please check appropriate box(es)):

Schedule(s) II ☐* III ☐ IV ☐ V ☐

Such delegation shall be in accordance with the provisions set forth in Section 303.05 a)2)B of the Illinois Controlled Substances Act.

_____ Print Name of Collaborating Physician

_____ Signature of Collaborating Physician

036 - _____ Illinois License Number of Collaborating Physician

336 - _____ Illinois Controlled Substance Number

Additional forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov.