

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 subject to discipline under the Act.

Notice of TERMINATION of Supervision and/or Delegated Authority (Advanced Practice Registered Nurse & Physician Assistant)

FOR PHYSICIAN ASSISTANT OR ADVANCED PRACTICE REGISTERED NURSE: Please complete the first section of this form, then forward it to your collaborating physician to complete the remaining sections and return the form to the Department.

COLLABORATING PHYSICIAN: Complete this form to formally notify the Department that the physician assistant's or advanced practice registered nurse's authority to prescribe controlled substances is being terminated.

- If the practitioner is a **Physician Assistant**, email the completed form to: fpr.medicalunit@illinois.gov
- If the practitioner is an **Advanced Practice Registered Nurse**, email the completed form to: fpr.nurseunit@illinois.gov

PHYSICIAN ASSISTANT OR ADVANCED PRACTICE NURSE INFORMATION

1. NAME OF PHYSICIAN ASSISTANT OR ADVANCED PRACTICE REGISTERED NURSE _____	2. ILLINOIS NUMBER FOR PHYSICIAN ASSISTANT OR ADVANCED PRACTICE REGISTERED NURSE _____
	3. ILLINOIS CONTROLLED SUBSTANCE LICENSE NUMBER FOR PHYSICIAN ASSISTANT OR ADVANCED PRACTICE REGISTERED NURSE _____
4. CONTACT NUMBER FOR PHYSICIAN ASSISTANT OR ADVANCED PRACTICE REGISTERED NURSE () _____	5. EMAIL FOR PHYSICIAN ASSISTANT OR ADVANCED PRACTICE REGISTERED NURSE () _____

Signature _____

PRIMARY SUPERVISING PHYSICIAN INFORMATION

1. SUPERVISING PHYSICIAN NAME _____	2. ILLINOIS LICENSE NUMBERS 036- _____ 336- _____
3. ILLINOIS PRACTICE ADDRESS (Street, City, State, Zip Code) _____	4. PHONE NUMBER OF PRACTICE (Include Area Code) () _____
	5. MEDICAL STAFF/CREDENTIALING FAX Fax: () _____

Date Supervisory Control and Delegated Prescriptive Authority was Terminated: _____
Month - Day - Year

Signature of Primary Supervising Physician: _____ Date Signed _____