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 Registered Practice Nurse)

APRN-CS

COLLABORATING PHYSICIAN:

Complete this form as official notification you are delegating prescriptive authority for controlled substances for the advanced practice nurse named herein. Email form to: fpr.nurseunit@illinois.gov or mail form to:

Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 West Washington, 3rd Floor HSS - NURSE
Springfield, Illinois 62786

Upon your decision to terminate the delegated prescriptive authority for controlled substances for this individual, you must notify the Department of your intent by completing a Notice of Termination of Delegated Prescriptive Authority.

This notice, as well as other forms required for Advanced Practice Nurse Licensure and for the Mid-level Practitioner Controlled Substance License, can be downloaded from the IDFPR Web site at: www.idfpr.illinois.gov.

1. NAME OF ADVANCED PRACTICE 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 Nurse Mid-level Practitioner Controlled Substances License** (Profession Name) **3 0 9** (Profession Code) 6. LICENSE NUMBER OF ADVANCED PRACTICE NURSE (If unknown, leave blank.)	
7. MAIDEN OR GIVEN SURNAME	8. APN CONTROLLED SUBSTANCE NUMBER	

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

prescriptive authority to_____ in order to prescribe and/or
(Advanced Practice 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 nurse's training. The advanced practice 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

_____
Date of Delegation of Prescriptive Authority

_____
Business Street Address of Collaborating Physician

_____
City, State, Zip Code

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