

Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810
Telephone: (225) 755-7500 or (225) 755-7517
www.lsbn.state.la.us

INSTRUCTIONS FOR REQUESTING A CHANGE OF PRESCRIPTIVE AUTHORITY PRIVILEGES TO ADD A PHYSICIAN(S) TO A PRACTICE SITE PREVIOUSLY APPROVED BY LSBN

INTRODUCTION

Prior to engaging in medical diagnosis and management as an Advanced Practice Registered Nurse (APRN), including writing orders and/or prescriptions, the APRN must obtain a letter of approval issued to the nurse by the Louisiana State Board of Nursing (LSBN) indicating approval for prescriptive authority (PA) privileges in the State of Louisiana in collaboration with the licensed physician(s) or dentist(s).

Standard processing time for a PA application is 10-15 business days from the date of receipt at LSBN. Applications are processed in the order received. If any information on the application is incorrect, incomplete or illegible, processing of the application may be delayed. *The APRN will be notified in writing as soon as the PA application has been approved or if additional information is required.* Applications which have not been approved by LSBN within 60 days of receipt at the Board office will be closed without approval.

The application forms contained in this packet have been formatted in such a way that allow the APRN to ‘type’ the required data in the appropriate fields (shown on-screen as ‘grey’ boxes) on the first form (PAC 1), and any repetitive fields for the same data will automatically be copied into subsequent forms. For this reason, Board staff encourages the APRN to type/enter data on-screen, and then print completed forms. NOTE: If a data field (‘grey’ box) on a form is **non-repetitive**, the information will need to be entered.

All Collaborative Practice Agreements (CPA) submitted to LSBN must include recently dated ‘*original*’ signatures of every party. All signatures should be in BLUE ink. White-out corrections are prohibited on the CPA and PA forms.

A [CPA template form](#) is available at the LSBN website. LSBN staff encourages the use of this template. If the APRN or his/her practice group wishes to draft their own CPA, it must comply fully with the guidelines for CPAs as provided for in L.R.S. 37:913 (3) (b), (8-9) and LAC 46:XLVII.4513. If the APRN’s practice site requires an ‘original’ CPA for their records, then two (2) original CPAs would need to be prepared, printed and signed by all parties - one (1) to submit to LSBN with applicable PA form(s) and one (1) for the practice site.

A ‘checklist’ is provided at the end of these instructions **for the APRN** as a guide to ensure he/she includes **all** documentation required by LSBN. Please follow this checklist carefully and **mail** all items listed on the checklist to LSBN **in one (1) envelope**. The APRN should make a copy of the full packet **prior** to submission. Instructions and checklist are for the APRN’s use and should not be returned to LSBN with the PA application.

ELIGIBILITY REQUIREMENTS

To Add a Physician to a Practice Site Previously Approved by LSBN

1. Each collaborating physician (or dentist) must hold an active and unencumbered Louisiana license.
 - License verification for physicians is available through the Louisiana State Board of Medical Examiners (LSBME): www.lsbme.la.gov.
 - License verification for dentists is available through the Louisiana State Board of Dentistry (LSBD): www.lsbdo.org.
2. APRN must hold a current, unencumbered Louisiana RN and APRN license issued by LSBN.
3. The APRN's advanced practice (AP) license, issued by LSBN, must be in the specific advanced practice role and population focus (e.g. adult, family, pediatric, psych/mental health, etc.) as indicated on the PA applications forms and CPA submitted for this practice site.
4. APRN must already hold current PA privileges approved in writing by LSBN for other collaborating physician(s) with the **same practice site**. This application is to request approval for **new physician(s)** that have joined the practice site previously approved by LSBN.

APRN RESPONSIBILITIES

- *The APRN is responsible* for obtaining written approval from LSBN for **all** collaborating physician(s) and/or dentists(s) **prior** to clinical practice.
- *The APRN is responsible* for advising LSBN in writing **within 30 days** regarding the deletion of a collaborating physician, dentist or practice site that had been previously approved by LSBN.
- *The APRN is responsible* for ensuring that a copy of his/her signed CPA and PA approval letters issued by LSBN are maintained at the clinical site where PA privileges are exercised and be able to produce this documentation for review during a site visit.
- *The APRN is responsible* for ensuring that the CPA and PA forms submitted to LSBN for review are complete and follow all instructions provided herein.
- *The APRN is responsible* for being familiar, knowledgeable and compliant with **all** current state and federal laws, rules and regulations affecting APRN practice including, but not limited to, the following:
 - LSBN Nurse Practice Act ([R.S. 37:911 et seq.](#))
 - LSBN Rules and Regulations (APRN Rules - LAC Title 46, Part XLVII, Subpart 2, [Chapter 45](#));
 - Louisiana State Board of Pharmacy (LABP) rules regarding prescribing practices (e.g. LAC 46:LIII.2511), www.pharmacy.la.gov
 - Federal law and regulations issued by the U.S. Department of Justice – Drug Enforcement Administration (DEA) www.deadiversion.usdoj.gov if APRN has been approved for controlled substances PA privileges by LSBN.
- **If** the APRN had been approved for controlled substances with the collaborating physician(s) previously approved by LSBN for the practice site, *the APRN should ensure* that the CPA signed between him/her and the **new** physician(s) and/or dentist(s) joining the practice site reflect the same DEA Schedule (i.e. III-V, II non-narcotic for ADD/ADHD, full II narcotics).
- **If the APRN selects 'Option A' on PAC 1 form** - *the APRN shall be responsible* for ensuring that the CPA signed with the new physician(s) or dentist(s) is identical in all aspects, content, and parameters of practice with the CPA previously approved by LSBN for this practice site.
- *The APRN is responsible* for notifying LSBN of a change in address and/or contact information for his/her primary place of residence **within 30 days**. Nurses may verify and update their address/contact information electronically at the LSBN website www.lsbn.state.la.us through 'My Services'.

CHECKLIST
To Add a Physician to a Practice Site Previously Approved by LSBN

The following forms/documents must be **mailed** to LSBN together in **one (1) envelope**:

- Completed **form PAC 1 – ‘Request for Approval – Additional Physician(s) in a Current Practice Site’** with original dated signature of APRN.

- Completed **form DOCP 1 – ‘Disclosure of Collaborating Physicians’**. Only the *new* physician(s) the APRN is requesting collaborative practice and PA approval should be noted on this form.
 - Louisiana medical license number and practice specialty area must be provided for each physician.
 - The names of the physicians listed on form DOCP 1 must match the physicians signing the CPA.
 - Please check the LSBME website www.lsbme.la.gov to ensure each collaborating physician has a current and unencumbered medical license. Collaborating dentists can be verified through the LSBD website: www.lsbdo.org

NOTE: **If** the APRN chooses ‘**Option B**’ on the PAC 1 form (“*I am submitting this PA request along with a CPA for review by LSBN*”), the original CPA signed by the APRN and new physician(s) or dentist(s) **must** be mailed to LSBN **along with** the PAC 1 and DOCP 1 forms indicated above.

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REQUEST FOR APPROVAL ADDITIONAL PHYSICIAN(S) IN CURRENT PRACTICE SITE (FORM # PAC 1)

The PAC 1 form is to be utilized *only* when requesting prescriptive authority (PA) privileges for collaborative practice with an **additional physician(s) for a practice site that has been previously approved by LSBN**. A completed DOCP 1 form **must** be submitted *along with* the PAC 1 form. Please refer to instructions for further information. The APRN will receive written verification sent to his/her home address of record to notify the nurse if the request has been approved, denied, or requires additional information.

APRN Name: _____
First Name Middle Name Maiden Name Married Name (If applicable)

Residence Address: _____
Street City State Zip

Email Address: _____ Home/Cell Phone: _____

Please check this box if any contact information provided above is **new**. Board staff will update your licensure file.

RN License # _____ APRN License# _____

Current role/category of practice as an APRN: CNS CNP CNM CRNA

Clinical population focus (Family, Pediatric, Adult, Psychiatric, etc.): _____

Position Title: _____

CURRENT PRACTICE SITE (applicable to **this** request to **add** new physicians):

Business/Site Name: _____

Primary Business Address for the above clinical practice site:

City State Zip Code Parish

CHECK HERE IF YOU AUTHORIZE LSBN TO SEND YOUR APPROVAL LETTER TO YOUR EMAIL ADDRESS

SELECT ONE (1) OPTION BELOW (required):

A. I am submitting this PA request *without* a Collaborative Practice Agreement (CPA) for review by LSBN. By checking this box (Option A), and with my signature below, **I affirm and attest to LSBN that I am in possession of a CPA signed by me and the new collaborating physician(s) or dentist(s) identified on the form provided - and - that this CPA is identical in all aspects, content and parameters of practice with the CPA previously approved by LSBN for collaborating physician(s) or dentist(s) with this practice site.**

- OR -

B. I am submitting this PA request along *with* a Collaborative Practice Agreement (CPA) for review by LSBN. By checking this box (Option B), and with my signature below, **I affirm and attest to LSBN that the CPA being submitted is an original with recent dated signatures by me and all new collaborating physician(s) or dentist(s) identified on the form provided for the practice site listed above.**

By signing below, I further affirm and attest that I am the APRN identified above submitting this request, have completed and reviewed the information and documents provided herein, and that I am in compliance with all LSBN rules including those relating to APRN and PA practice as specified in accord with LAC Title 46, Part XLVII, Subpart 2, [Chapter 45](#):

Signature: _____ Date Signed: _____
Original Signature of APRN

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DISCLOSURE OF COLLABORATING PHYSICIANS (FORM # DOCP 1)

Complete DOCP 1 form(s), providing **all** information requested, and submit to LSBN *along with* appropriate prescriptive authority (PA) application form(s) and original collaborative practice agreement (CPA). Please refer to the PA instructions to determine if a fee must accompany the submission to LSBN. Additional DOCP 1 forms may be utilized if needed to list all physician(a) and/or dentist(s) with this practice site. **The names of the physician(a) and/or dentist(s) listed on the DOCP 1 form(s) must match those signing the CPA for the practice site.** All collaborating physician(s) and/or dentist(s) must hold an active and unencumbered Louisiana license.

APRN Name: _____
First Name Middle Name Maiden Name Married Name (If applicable)

RN License # _____ APRN License# _____

COLLABORATING PHYSICIAN(S)

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

BACK UP PHYSICIAN(S)

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____

Physician Name: _____

LA Medical License #: _____

Practice Specialty: _____