LOUISIANA STATE BOARD OF NURSING

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

VERIFICATION OF PRACTICE AS AN ADVANCED PRACTICE REGISTERED NURSE (FORM # VOP 1)

In accordance with LAC 46:XLVII.4513.D.1.(e) (i) and §4513.D (g), an APRN is required to submit the VOP 1 form *along with* the application for licensure by endorsement or prescriptive authority (PA) privileges only when **either** of the following conditions applies:

- The APRN has not been issued PA privileges by LSBN previously and wishes to now apply for licensure by endorsement and/or *Initial Prescriptive Authority* in Louisiana – ***and*** – it has been 2 years (or more) since completion of the APRN's masters/graduate program for which he/she was licensed by LSBN. - ***OR*** -
- The APRN had PA privileges awarded by LSBN previously and wishes to apply for *Reinstatement of Prescriptive Authority* - ***and*** - the APRN has ceased practicing with his/her collaborating physician(s) and/or dentist(s) previously approved by LSBN for 4 years or more.

********The VOP 1 form is to be utilized by the APRN to demonstrate evidence of 500 hours of clinical practice within the previous 2 years in the specific advanced practice role and population focus for which the nurse was educationally prepared as an APRN. APRN practice in another state may be accepted to meet this requirement.

Nurses who have been issued APRN licensure by LSBN immediately after graduation **- *and* -** apply for initial PA privileges in Louisiana within 2 years of his/her graduation date do ***not*** need to submit this VOP 1 form along with their request for initial prescriptive authority.

The VOP 1 form must be completed and signed by your collaborating physician, employer or department head, and submitted to LSBN *along with* the appropriate licensure or PA application as explained above.

Name of APRN: _____
First Name Middle Name Maiden Name (If applicable) Last Name

Social Security Number: _____ Date of Birth: _____

APRN's Educationally Prepared Role: ☐ CNS ☐ CNP ☐ CNM ☐ CRNA

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

Check one (1) box: ☐ I am applying for Initial Prescriptive Authority Privileges or Reinstatement of PA in Louisiana, ***OR***
☐ I am applying for licensure as and APRN by Reinstatement or Endorsement

Employer Verifying APRN Practice: _____
Name of Clinic/Agency

Street/physical address of the clinical practice site named above: _____

_____
City State Zip Code Country

Job Title/Position APRN held during employment: _____

Employment – check one (1) box: ☐ Full-time **-OR -** ☐ Part-time

Overall Employment Period: **From/Hire Date:** _____ **To:** _____

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I certify with my signature that the information provided is correct and that the APRN indicated above had *most recently* achieved 500 hours of clinical practice in the APRN role & population focus indicated between the dates provided below:

Verification of 500 hours achieved between: _____ and _____ (DATEs **must** be provided)

_____ _____ _____
Signature of Employer/Verifier Date Signed **Type/Print** Name of Employer/Verifier

_____ _____
Position/Title of Employer/Verifier Phone Number or Email of Employer/Verifier

Revised: 3/02, 12/03, 4/04, 2/05, 8/05, 3/06, 8/06, 2/08, 3/12, 4/14, 11/16