

***(Must be on company or physician letterhead)***

**Documentation/Verification of the  
Prescribing of Drugs, Medicines, and Therapeutic Devices**

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**TO: Arkansas State Board of Nursing, Advanced Practice Department**

I confirm that \_\_\_\_\_, APRN, has completed \_\_\_\_\_ hours in the prescription of drugs, medicines, and therapeutic devices within the last year.

**Physician/APRN or Clinic Representative Signature:** \_\_\_\_\_

**Physician/APRN Title & Specialty:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**AFFIDAVIT VERIFYING SIGNATURE (Above)**

**State of** \_\_\_\_\_ **County of** \_\_\_\_\_

**Sworn to before me this** \_\_\_\_\_ **day of** \_\_\_\_\_ **20** \_\_\_\_\_

**My Commission Expires:** \_\_\_\_\_

**Notary Public Signature:** \_\_\_\_\_

**Notary Seal:**