



ARKANSAS STATE BOARD OF NURSING

1123 S. University Avenue, Suite 800 • Little Rock, Arkansas 72204
Phone: (501) 686-2700 • Fax: (501) 686-2714 • Web: www.arsbn.org

ADVANCED PRACTICE LICENSURE VERIFICATION FORM

Applicant: Complete Section 1 below and forward this form to the Board of Nursing in the state where you are currently licensed as an APRN &/or have prescriptive privileges.

SECTION 1:

<u>Name (Last, First, Maiden / Middle)</u>		
<u>Mailing Address</u>		
<u>City</u>	<u>State</u>	<u>Zip Code</u>
<u>RN License Number</u>	<u>Advanced Practice License Number</u>	<u>Prescriptive Authority Number</u>

SECTION 2 (TO BE COMPLETED BY THE BOARD OF NURSING):

The above named APRN has applied for an Arkansas APRN license &/or Prescriptive Authority. Please complete Section 2 and mail directly to the address above, attention to Adv. Practice Dept.

I hereby verify that _____ has met the initial criteria for
(print name)
Advanced Practice licensure &/or Prescriptive Authority.

Does the licensee currently hold an Advanced Practice license in your jurisdiction? Yes No

Is the licensee currently authorized to prescribe in your jurisdiction? Yes No

Is Prescriptive Authority automatically granted with APRN licensure? Yes No

Advanced Practice License #: _____ Date of Issuance: _____

Prescriptive Authority License/Certificate #: _____ Date of Issuance: _____

Has license/certificate ever been encumbered? *Yes No

**If yes, please attach a certified copy of Board order.*

Is applicant currently under investigation? Yes No

Executive Director: _____

State of: _____

Seal

Date: _____
Month Day Year