

REQUIREMENTS/INFORMATION - ADVANCED PRACTICE REGISTERED NURSES PRESCRIPTIVE AUTHORITY (APRN-RX)

Access this form via website at: www.hawaii.gov/dcca/areas/pvl

NO RECIPROCITY

Hawaii does not reciprocate with any other state or jurisdiction. Each applicant is required to meet requirements according to Hawaii laws and rules.

DEFINITIONS

"Advanced practice registered nurse (APRN)" means a Hawaii licensed registered nurse who has met the requirements of and received recognition as an advanced practice registered nurse from the Board of Nursing as a nurse practitioner, clinical nurse specialist, certified nurse midwife or nurse anesthetist.

"Board" means the Hawaii Board of Nursing.

"Collegial" means the power or authority vested equally in each of the working parties.

"Contact hour" means a minimum of fifty minutes of actual organized instruction. Academic credit will be converted to contact hours as follows:

- (1) One quarter academic credit equals ten contact hours; and
- (2) One semester academic credit equals fifteen contact hours.

"Department" or "DCCA" means the department of commerce and consumer affairs.

"Institution" means hospitals, health maintenance organizations, home health agencies, hospice programs, community health centers receiving State or federal funds, state agencies, clinics, physicians' offices, long term care facilities, and authorized contractors of the State.

"Physician" means a person licensed under chapter 453 or 460, Hawaii Revised Statutes.

"Recognized national certifying body" means credentialing agencies recognized by the board which include the American Nurses Credentialing Center; the National Certification Board of Pediatric Nurse Practitioners/Nurses; the National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties; the American College of Nurse Midwives Certification Council; the American Academy of Nurse Practitioners; or a national certifying body which is a successor to any body listed and recognized by the board.

PREREQUISITES

Each applicant is required to have a current and unencumbered recognition as an Advanced Practice Registered Nurse ("APRN") **and** be currently licensed as a Registered Nurse ("RN") in Hawaii. Three separate applications are required: RN, APRN and APRN-RX.

DOCUMENTS REQUIRED

1. Application form: You must attach the \$50 application fee (non-refundable) for your application to be reviewed. You may attach the other fees or you may send those in later upon approval of your application; however, the effective date of your prescriptive authorization will be delayed until all fees have been paid.

We are creating a separate file for APRN-RX recognition. As such, this file requires original documentation as required below. Similar documents that may be in Hawaii APRN recognition file will not be transferred unless recognition granted no more than 12 months prior.

2. Master's degree transcript: Arrange with your school to have your official transcript of a master's degree in clinical nursing or nursing science sent directly to the Department of Commerce & Consumer Affairs ("DCCA").
3. Certification of nursing practice specialty: Arrange with the recognized national certifying body to have proof of your current certification sent directly to DCCA.
4. Proof of education in advanced pharmacology, including advanced pharmacotherapeutics: Arrange with your educational institution or continuing education course provider to provide verification of the item you checked in question 3 of your application form. Refer to rules for continuing education requirements.

To facilitate the review of your application, and to receive proper credit for your coursework, attach course descriptions from your college/university catalog or continuing education course provider. The applicant has the burden of proving he/she meets recognition requirements.

5. Proof of 1,000 hours of clinical experience in nursing specialty: You must use the form included in this packet. Hawaii requires a minimum of 1,000 hours of clinical experience in an institution (hospital, health maintenance organization, home health agency, hospice program, community health center receiving State or federal funds, state agency, clinic, physician's office, long term care facility, and authorized contractor of the State) as a Hawaii Nursing Board-recognized APRN practitioner in the applicant's nursing practice specialty, within a three-year time period immediately preceding the date of application. This form must be completed by someone other than yourself. **The 1,000 hours accumulate only after you have been granted APRN recognition by the Board.**

(CONTINUED ON BACK)

**DOCUMENTS
REQUIRED
(cont.)**

- 6. Collegial Working Relationship Agreement: You must use the form included in this packet. Submit the completed original form. Be advised that any illegible or unclear information will necessitate return of the form to the applicant for clarification. **YOU MUST ALSO INCLUDE YOUR INTERIM PHYSICIAN ("I") ON THIS FORM.**

NOTE: If you hold more than one (1) approved APRN specialty, your APRN-RX license will not automatically reflect all specialties. Only specialty(ies) indicated on your collegial working relationship agreement form will be acknowledged.

Section 16-89C-10, HAR, requires each relationship between a recognized APRN with prescriptive authority and a licensed physician shall be documented in an agreement, the form of which is provided by the department, which attests that:

(a)(1) "The physician shall be actively engaged in the same or related specialty practice and affiliated with the same institution in which the recognized APRN is to practice." An example of this is a collegial agreement of a Family Nurse Practitioner with physicians in Family Medicine or Internal Medicine.

FEES

Submit appropriate payment as follows (make check payable to "COMMERCE AND CONSUMER AFFAIRS");

If you expect prescriptive authority to be granted in an EVEN-NUMBERED year, pay\$160
(\$50* - application fee + \$20 - RX fee + \$70
- Compliance Resolution Fund + \$20 - 1/2 renewal)

If you expect prescriptive authority to be granted in an ODD-NUMBERED year, pay\$105
(\$50* - application fee + \$20 - RX fee + \$35 - Compliance Resolution Fund)

*The \$50 application fee is non-refundable.

Modification of the Collegial Working Relationship Agreement between a recognized APRN and Physician fee (modification made after approval of the initial Agreement) pay\$50

NOTE: One of the numerous legal requirements that you must meet in order for your new recognition to be issued is the payment of fees as set forth in this application. You may be sent a recognition certificate before the payment you sent us for your required fees is honored by your bank. If your payment is dishonored, you will have failed to pay the required RX fee and your recognition will not be valid, and you **may not** do business under that recognition. Also, a \$25.00 service charge shall be assessed for payments that are dishonored for any reason.

If for any reason you are denied the recognition you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for recognition has been denied.

**MAILING
ADDRESS**

Board of Nursing
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801
or
Deliver to office location at:
335 Merchant St., Room 301
Honolulu, HI 96813

Phone: (808) 586-3000

Toll free voice access numbers for the neighbor islands:

Kauai - 274-3141 Ext. 6-3000
Maui - 984-2400 Ext. 6-3000
Hawaii - 974-4000 Ext. 6-3000
Molokai - 1-800-468-4644 Ext. 6-3000
Lanai - 1-800-468-4644 Ext. 6-3000

**APPLICATION
STATUS**

APRN prescriptive authority requirements are subject to change as a result of new laws or rules, or from new policies and procedures adopted by the Hawaii Board of Nursing. Applicants must meet current recognition requirements.

It is the responsibility of the applicant to arrange for submission of all required documentation for timely completion of the application. The DCCA does NOT have an obligation to notify applicants of incomplete documentation. Applicants may contact DCCA periodically to monitor the status of their file with regard to the receipt of supporting documents.

You may write, or call the Licensing Branch at (808) 586-3000. We do not accept, nor send, application materials by fax.

ABANDONED APPLICATIONS

Pursuant to HRS §436B-9 your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years. The failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit any required information and documents requested by the licensing authority within two consecutive years from the last date the documents and information were requested, or (2) failure to complete any additional requirements for licensure that remain after approval of your application, such as attempting to complete an exam requirement, within two consecutive years from the date your application was approved, or (3) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process. If an application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

LAWS AND RULES

APRN-RX is held accountable for knowing and complying with the laws and rules of advanced practice registered nurse prescriptive authority practice as failure to comply may result in disciplinary action. Obtain copies by submitting a written request to APRN-RX Authority, Commerce and Consumer Affairs, P.O. Box 3469, Honolulu, HI 96801. Please indicate the specific chapters in your request.

- Advanced Practice Registered Nurse Prescriptive Authority, Hawaii Administrative Rules, Chapter 89C
- Nurses, Hawaii Revised Statutes, Chapter 457
- Nurses, Hawaii Administrative Rules, Title 16, Chapter 89
- Professional & Vocational Licensing Law, Hawaii Revised Statutes, Chapter 436B
- *Food, Drugs & Cosmetics, Hawaii Revised Statutes, Chapter 328

***Note:** For your information, the Department of Health, Food and Drug Branch, has jurisdiction over the laws relating to drugs (Chapter 328, HRS). Questions relating to prescriptions and over-the-counter drugs, other laws relating to drugs, and information on how to obtain a copy of the laws and rules should be directed to the Department of Health, Food and Drug Branch at (808) 586-4725.

The laws and rules are also posted on the internet at: www.hawaii.gov/dcca/areas/pvl. Click on "APRN-RX".

ADDRESS CHANGES

Report your change of address in writing. Report each change of address separately, and the effective date of change.

RENEWAL OF RECOGNITION

All APRN-RX authority, **regardless of when issued**, expire on December 31 of each **odd-numbered** year and are subject to renewal by the expiration date. A "Renewal Application" is mailed approximately 60 days prior to the expiration date to your last address on file with DCCA. DCCA is not responsible for non-receipt of any mail. The burden is on the APRN-RX to ensure that his/her recognition is kept current.

Refer to section 16-89C-20, Advanced Practice Registered Nurse Prescriptive Authority, Hawaii Administrative Rules, for license renewal requirements on current certification, continuing education, etc.

ORAL CODE DESIGNATION

The Department of Health, Food & Drug Branch, in cooperation with the Department of Public Safety, Narcotics Enforcement Division ("NED"), has jurisdiction over assignment of your oral code designation.

When DCCA approves your application for prescriptive authority, you will be mailed an "Application for Oral Code" form and instructions, together with your "Notice of Prescriptive Authority". You may submit the "Application for Oral Code" to the Narcotics Enforcement Division at that time, if you wish to have an oral code.

MAINTENANCE OF LICENSE

Once your prescriptive authority is granted, you are required by law to inform us of a change in physician(s) at least 10 working days prior to the intended implementation of the change (§16-89C-10(c), HAR). Failure to do so could affect your authority to prescribe.

Any encumbrance on one nurse license shall automatically and similarly affect any other nursing license, recognition as an APRN, or prescriptive authority held by that nurse (§16-89C-25, HAR). See §16-89C-30, HAR for grounds for disciplinary action.

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

**APPLICATION - ADVANCED PRACTICE REGISTERED NURSE
PRESCRIPTIVE AUTHORITY (APRN-RX)**

Read the attached instructions before completing this form. Print legibly or type

Legal Name (First, Middle)		(LAST)	OFFICE USE ONLY	Approval date	Ineligible	Initial
Other Names Used (include maiden name)				Date Effective:	Recognition No. RX-	
Residence Address (include Apt. No., City, State and Zip Code) – REQUIRED				RN -	Exp 6/30/_____	
Mailing address (only if different from above)				APRN -	Exp 6/30/_____	
				Category Code:		
Social Security No.	Hawaii APRN Recognition No. APRN-	Effective date of Hawaii Recognition				
Phone No. (days)	Board of Nursing Approved Specialty/Code:					
Hawaii RN License No. RN-						

Circle answers and provide details when required:

1. Have you arranged for an official transcript of a master's degree in clinical nursing or nursing science, be sent directly from the school to DCCA?.....YES NO
 Name of school: _____ Graduation date: _____
2. Have you arranged for verification of current certification in your practice specialty, be sent from a national certifying body recognized by the Hawaii Board of Nursing to DCCA?YES NO
 Name of certifying body: _____
3. Which one of the following have you successfully completed within the three-year period immediately preceding this application AND have you enclosed verification of such successful completion from your educational institution or national certifying body?
 - a. _____ At least 30 contact hours*, as part of a master's degree program from an accredited college/university, of advanced pharmacology education, including advanced pharmacotherapeutics that is integrated into the curriculum?YES NO
 OR
 - b. _____ At least 30 contact hours* of advanced pharmacology, including advanced pharmacotherapeutics, from an accredited college/university?YES NO
 OR
 - c. _____ At least 30 contact hours* of continuing education from a Hawaii Board of Nursing approved recognized certifying body, in advanced pharmacology, including advanced pharmacotherapeutics related to your practice specialty?YES NO
 Name of school/provider: _____

* Contact hours means a minimum of fifty minutes of actual organized instruction. Academic credit shall be converted to contact hours as (1) one quarter academic credit = 10 contact hours, or (2) one semester academic credit = 15 contact hours.

(Continued on Back)

App	700	\$50
RX fee	705	\$20
CRF	712	\$35/\$70
½ Ren	706	\$20
Service Charge	BCF	\$25

4. Do you have at least 1,000 hours of clinical experience in an institution as a Hawaii Nursing Board-recognized APRN practitioner in your nursing practice specialty, within a three-year period immediately preceding the date of this application AND have you completed and enclosed the Certification of Clinical Experience form? YES NO
5. In the past twenty years, have you ever been convicted of a crime for which the conviction has not been annulled or expunged? YES NO
If "YES", arrange to have certified court documentation on the date, place, violation for each conviction and fulfillment of conditions of each sentence sent directly to DCCA.
- 6a. List all states in which you are currently recognized or licensed as an APRN-RX:
- State _____ No. _____ Expiration Date _____
- State _____ No. _____ Expiration Date _____
- State _____ No. _____ Expiration Date _____
- b. Has any of the above prescriptive authority, recognition, or licenses ever been revoked, suspended, or otherwise subject to disciplinary action? YES NO
If "YES", arrange to have certified documents from the state in which disciplinary action was taken, sent directly to DCCA. (Include Findings of Fact, Conclusion of Law, Recommended Order, Final Order, and whether you have been reinstated. If re-instated, date and conditions of license.)
- c. Are you presently being investigated or is any disciplinary action pending against any of the licenses, prescriptive authority, recognitions, certifications, or registrations you hold? YES NO
If "YES", arrange to have certified documents from the state in which disciplinary action or investigation is pending against you, sent directly to DCCA.

AFFIDAVIT OF APPLICANT:

I hereby certify that the statements, answers and representations made in this application and in the documents attached are true and correct. I understand that any misrepresentation is grounds for refusal to grant or subsequent revocation of recognition and is a misdemeanor (Section 710-1017, Sections 436B-19 and 457-12, Hawaii Revised Statutes). I also certify that I have read, understand, and agree to comply with Chapters 89 and 89C, Hawaii Administrative Rules for Advanced Practice Registered Nurse practice and APRN Prescriptive Authority.

Date

Signature of Applicant

STATE OF HAWAII
ADVANCED PRACTICE REGISTERED NURSE
PRESCRIPTIVE AUTHORITY RECOGNITION PROGRAM
Department of Commerce and Consumer Affairs
P.O. Box 3469
Honolulu, HI 96801

CERTIFICATION OF CLINICAL EXPERIENCE

(print name of applicant)

This is to certify that _____
(name of applicant)

has practiced as a Hawaii Board of Nursing-recognized Advanced Practice Registered Nurse in the area of
_____ at _____ hours per
(nursing practice specialty) (no. of hours)
week from _____ through _____ for a total of _____ hours
*(month/day/year) (month/day/year) (number)

at the institution named below.

Signature (Employer) (Date)

Print Name

Title

Name of Institution

Address

City State Zip Code

() _____
Telephone Number

* This date **cannot** be earlier than the date applicant received APRN Recognition from the Hawaii Board of Nursing.

THIS FORM MAY BE DUPLICATED

STATE OFFICE USE ONLY

Recognition No. APRN-RX	Eff. Date	Exp. Date
APPROVED:	_____ Initial _____ Modification	

COLLEGIAL WORKING RELATIONSHIP AGREEMENT BETWEEN A RECOGNIZED ADVANCED PRACTICE REGISTERED NURSE AND A PHYSICIAN(S)

This form may be used for collegial working relationship agreements with multiple physicians provided each physician separately answers all the questions, signs and notarizes his/her portion of this document. This form can also be duplicated if there are more than 4 collegial working relationship agreements. This form must be filed for approval at least 5 weeks prior to the intended implementation of the below named collegial working relationship.

Note: Modification of the Collegial Working Relationship Agreement after approval of the initial agreement requires a fee of \$50. In addition to this form, please submit a letter of the status of all physicians you have on record with the Board.

I. Name of APRN seeking initial, renewing or modifying prescriptive authority _____

Business address _____
Business phone number
Emergency/after hours phone number

Board of Nursing approved practice specialty(ies) (List all that apply.) _____

II. Collegial Working Relationship Physician(s) (**INCLUDING INTERIM PHYSICIAN'S** which should use the code "I" in the "I" column). Both MD's must be at the same institution as the APRN.

Physician's License Name	Physician's Hawaii License No. and Expiration Date	Affiliated* Institution of Practice w/ APRN-RX	I	Area of Practice	Certify to a. below (yes or no)	Certify to b. below (yes or no)	If applicable, list any limitation to the Exclusionary Formulary	Department Use only (approved/disapproved)
1.	-----							
2.	-----							
3.	-----							
4.	-----							

- a. I am actively engaged in the same or related specialty practice and affiliated with the same institution in which the above-named APRN-RX is to practice.
- b. In my collegial working relationship with the above-named APRN-RX applicant, I have established methods of communication between myself and the APRN-RX.

*If the area of practice for the physician does not match exactly your area of practice, attach separate sheet of explanation.

(CONTINUED ON NEXT PAGE)

Modif Fee 707 \$50
 Service Charge BCF \$25

Name of APRN seeking prescriptive authority

III. For the APRN-RX candidate and physician(s): The notarized signature below represents our attestation of the following:

- a. We certify that we jointly acknowledge and accept the responsibility that the collegial working relationship is based upon written policies for the delivery of health care services that will have the interest and welfare of the patient foremost in mind;
- b. We certify that we acknowledge and accept the responsibility that the above-named APRN who is applying for prescriptive authority shall be governed by the exclusionary formulary (or any limitations named above) and that there shall be strict adherence to the exclusionary formulary (or any limitations named above) and the applicable provisions of Chapters 89 & 89C, HAR;
- c. We certify that the collegial working relationship shall not commence until the Hawaii Board of Nursing (HBON) has granted approval;
- d. We certify that we will notify the HBON, at least 10 working days prior to any modification of any of the above stated information and attestations, and such modified collegial working relationship shall not commence until after the Department has granted approval; and
- e. I agree to provide notice to the HBON within 3 calendar days, when our collegial working relationship is terminated.

(Collegial Working Relationship Agreement 1)

Subscribed and sworn to before me
_____ day of _____, 20 ____
this _____
Notary Public, State of _____
My commission expires: _____

APRN-RX signature

Subscribed and sworn to before me
this _____ day of _____, 20 ____

Notary Public, State of _____
My commission expires: _____

Physician signature

(Collegial Working Relationship Agreement 2)

Subscribed and sworn to before me
_____ day of _____, 20 ____
this _____
Notary Public, State of _____
My commission expires: _____

APRN-RX signature

Subscribed and sworn to before me
this _____ day of _____, 20 ____

Notary Public, State of _____
My commission expires: _____

Physician signature

(Collegial Working Relationship Agreement 3)

Subscribed and sworn to before me
_____ day of _____, 20 ____
this _____
Notary Public, State of _____
My commission expires: _____

APRN-RX signature

Subscribed and sworn to before me
this _____ day of _____, 20 ____

Notary Public, State of _____
My commission expires: _____

Physician signature

(Collegial Working Relationship Agreement 4)

Subscribed and sworn to before me
_____ day of _____, 20 ____
this _____
Notary Public, State of _____
My commission expires: _____

APRN-RX signature

Subscribed and sworn to before me
this _____ day of _____, 20 ____

Notary Public, State of _____
My commission expires: _____

Physician signature