

MONTANA BOARD OF NURSING
PO Box 200513 (301 S Park, 4th Floor)
Helena, MT 59620-0513
LICENSING PHONE: (406) 444-5711
EMAIL: nurse@mt.gov WEBSITE: www.nurse.mt.gov

INSTRUCTIONS TO APPLY FOR APRN PRESCRIPTIVE AUTHORITY ENDORSEMENT:

- FEES:**
 - Application fee is \$100.00.
 - Fees are payable to the Montana Board of Nursing by check, money order, or cashier's check.
 - Please enclose your payment with your application.
 - All application fees are NON-REFUNDABLE and must be received with your application to insure proper processing.

- INITIAL LICENSURE REQUIREMENTS:** (See rule [24.159.1463](#))
 - Possess a current Montana RN license or a current RN license from another Nurse Licensure Compact state, and an APRN license, or applying for an APRN license.
 - If you have graduated from an accredited program in the last 5 years, submit:
 - a. Evidence of successful completion of a graduate level course of three semester credits in advanced pharmacology that includes instruction in pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents.
 - b. Evidence of successful completion of a graduate level course that includes differential diagnosis/disease management.
 - c. Evidence of supervised clinical practice that integrates pharmacologic intervention with patient management.
 - If you have graduated from an accredited program more than 5 years ago, must complete: either a graduate level course of three semester credits or 45 contact hours of continuing education (during the last 5 years) that includes instruction in pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents.

- LICENSURE BY CREDENTIALING REQUIREMENTS (If you have Prescriptive Authority license in another state. Also referred to as ENDORSEMENT in the Board of Nursing rules.):** (See rules [24.159.1418](#) and [24.159.1463](#))
 - Possess a current Montana RN license or a current RN license from another Nurse Licensure Compact state, and an APRN license, or applying for an APRN license.
 - The applicant is responsible for including evidence of a current unencumbered APRN license with prescriptive authority in another board jurisdiction. (Use the License Verification form).

- RENEWAL:**
 - All licenses expire on December 31st of even numbered years.
 - Renewal notices are mailed 45 days prior to the expiration date to your address of record. Change of address form is available at www.nurse.mt.gov, under the Forms tab.

- CONTINUING EDUCATION:** (See rule [24.159.1468](#))
 - Must complete 12 contact hours of continuing education during each 2 year license renewal period in pharmacology, pharmacotherapeutics, and/or clinical management of drug therapy.
 - The prescriptive authority contact hours can be used to satisfy 12 of the required 24 contact hours to renew the general APRN license.

- **NON-ROUTINE APPLICATIONS:** (see [ARM 24.159.403](#))
 - If the completed application is non-routine, there may be a delay in processing.
 - The Board may request that you provide additional information, and you may be requested to be available in person or by phone for the Board during a regularly scheduled board meeting.
 - A complete application must be received by the board 15 business days prior to a scheduled board meeting. Please refer to our website for Board meeting dates.

- **IMPORTANT INFORMATION FOR ALL APPLICANTS:**
 - The applicant will be notified of any deficiencies in their application.
 - Official licensure status can be accessed via the "Licensee Lookup" system on the board website, www.nurse.mt.gov.
 - It is the responsibility of the applicant to keep the board office informed of any name changes, address changes, changes in licensure status, complaints or proposed disciplinary action against you in this or any other state. The change of address form is available at www.nurse.mt.gov, under the Forms tab.

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED. Application Fees must be paid before your application can be reviewed. *When the Board has all necessary documentation, your application will be processed.* Incomplete applications expire 12 months from the date received by the Board of Nursing.

APRNs ARE NOT PERMITTED TO PRACTICE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA APRN LICENSE and if APPLICABLE, A PRESCRIPTIVE AUTHORITY ENDORSEMENT

APPLICATION FOLLOWS

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Application for Prescriptive Authority (Please choose one of the following): \$100.00

INITIAL PRESCRIPTIVE AUTHORITY LICENSURE

LICENSURE BY CREDENTIALING (If you have a Prescriptive Authority license in another state)

Other state(s) licensed in: _____

Allow 30 business days from the date the Board office has received all required documentation for processing a routine application.

PLEASE PRINT OR TYPE

1. FULL NAME: _____
 First Middle Last
2. SOCIAL SECURITY NUMBER: _____
3. OTHER NAME(S) KNOWN BY (i.e. maiden name): _____
4. EMAIL ADDRESS: _____
 (Email is the Board's primary method of communication)
5. DATE OF BIRTH: _____
6. GENDER: Female Male
7. MAILING ADDRESS: _____
 City _____ State _____ Zip Code _____
8. TELEPHONE Home: _____ Mobile: _____
9. MONTANA APRN LICENSE: Yes No
10. EDUCATION IN PHARMACOLOGY: (Attach documentation)

DECLARATION

I authorize the release of information concerning my education, training record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Nursing. I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant _____ Date _____

REQUEST FOR OFFICIAL VERIFICATION OF LICENSURE

APPLICANT: Do **NOT** send this form in with your application. This is to be used as necessary to request official license verification from states or licensing entities in which you currently hold or ever have held a license. Complete the form and mail it to any state board in which you are requesting official license verification be sent to the Montana Board of Nursing. You may make as many copies of this form as you wish. Be advised that some boards require a fee for this service. It is recommended you contact the board(s) prior to mailing in this form to see if you need to include payment.

LICENSEE INFORMATION

To Whom It May Concern:

I am applying for a license to practice Nursing in the State of Montana and the Nursing Board requires official license verification. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to:

Montana Board of Nursing
PO Box 200513
Helena, MT 59620-0513
Or
Email at: unitb@mt.gov

Your prompt response is appreciated.

Name (Please Print) _____ Signature _____

Address: _____

Street or PO Box #

City

State

Zip

My License Number from your State is: _____ License Type: _____