



FOR OFFICE USE ONLY
Receipt #
ID #
Issue Date
License #

**Rhode Island
Board of Nurse Registration and Nursing Education**

Room 103
3 Capitol Hill
Providence, RI 02908-5097

***Instructions and
License Application for APRN:
Select 1 Population Focus***

- | | |
|--|---|
| CNP Adult/gerontology | CNS Adult/gerontology |
| CNP Family/individual across the lifespan | CNS Family/individual across the lifespan |
| CNP Neonatal | CNS Neonatal |
| CNP Pediatric | CNS Pediatric |
| CNP Psychiatric/mental health | CNS Psychiatric/mental health |
| CNP Women's health/gender related | CNS Women's health/gender related |
| CRNA Family/individual across the lifespan | |

MILITARY STATUS ELIGIBILITY	<i>(Documentation Required) see next page for instructions</i>
Please check ONE of the following criteria for expedited application:	
<input type="checkbox"/> I am in active military duty or a reservist	
<input type="checkbox"/> I am a military veteran with honorable discharge	
<input type="checkbox"/> I am the spouse of someone in active military duty or the spouse of a reservist	

Applicant - Print Name

<i>LAST NAME</i>	<i>FIRST NAME</i>	<i>MI</i>

Do Not Hand Deliver - Application Must Be Mailed

Phone: (401) 222-5700

TTY/TDD: (800) 745-5555

Fax: (401) 222-6683

Licensure Requirements

- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$145.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- Official transcript from the educational program, submitted by the college/school/university, directly to the Board. Transcript must include date of completion, graduation date and degree. You must be a graduate of a nursing program.
- Copy of Active RN license in Rhode Island
- Letter of APRN certification from professional certifying organization
- National Criminal Background check supported by fingerprints. This report MUST be sent directly from the Department of Attorney General (AG) to the RI Board of Nursing. For information on this process please visit their website at <http://www.riag.state.ri.us/homeboxes/BackgroundChecks.php> or call 401-274-4400.
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held an advanced practice nurse license. (Interstate Verification Form included in this application can be used for that purpose) Please visit the National Council of State Boards of Nursing website at: www.ncsbn.org to obtain contact information for all U.S. licensing authorities.
- If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Rhode Island Controlled Substance Registration (CSR) - Application Fee - \$200.00

- Completed Rhode Island Uniform Controlled Substances Act Registration Form (CSR) enclosed in this application to be used for that purpose.

In order to dispense, prescribe, store, or order controlled substances, **you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.** After you obtain your Rhode Island CSR you must apply for a federal DEA Number. That DEA number must be registered to a RI Business Address. An application for the federal DEA Number can be obtained by contacting DEA: DEA Phone Number (617) 557-2200. Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps

Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



State of Rhode Island

Board of Nursing Registration and Nursing Education

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., Dr., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

 - -

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."

3. Gender

 Male Female

4. Date of Birth

 / /

Month Day Year

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

 -

State Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 -

Home Phone

 -

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

 -

State Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 -

Business Phone

Extension

 -

Business Fax

<p>7. Preferred Mailing Address Please check <u>ONE</u></p>	<p><input type="checkbox"/> Please use my Home Address as my preferred mailing address</p> <p><input type="checkbox"/> Please use my Business Address as my preferred mailing address</p>
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<p>8. Qualifying Education</p> <p>Please list the name and information about the school that you attended which led to your advanced practice license.</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="height: 20px;"> </td> </tr> <tr> <td style="font-size: 8px;">Type of School (University, College, Trade/Technical School etc.)</td> </tr> <tr> <td style="height: 20px;"> </td> </tr> <tr> <td style="font-size: 8px;">Name of School</td> </tr> <tr> <td style="height: 20px;"> </td> </tr> <tr> <td style="font-size: 8px;">Year Graduated: <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> <tr> <td align="center" colspan="4" style="font-size: 8px;">Year</td> </tr> </table></td> </tr> </table>		Type of School (University, College, Trade/Technical School etc.)		Name of School		Year Graduated: <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> <tr> <td align="center" colspan="4" style="font-size: 8px;">Year</td> </tr> </table>					Year			
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<p>9. Certification</p> <p>Please provide your Certification Information here.</p>	<p>Organization Granting Certification _____</p>
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<p>10. Original APRN State License</p> <p>Please answer the question and list state(s), if applicable</p>	<p>Have you ever held, or do you currently hold, a license in another state? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the answer to this question is “yes”, list the original state of licensure, license number, original issue date, and, if applicable, enter all other state abbreviation(s) of licenses in Question 11 (below):</p> <table style="width:100%;"> <tr> <td align="center" style="width:60%;">Original Licensure State and License Number</td> <td align="center" style="width:40%;">Original Issue Date</td> </tr> <tr> <td> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:40px; height: 20px;"> </td> </tr> <tr> <td align="center" style="font-size: 8px;">State</td> <td></td> <td align="center" style="font-size: 8px;">License Number</td> </tr> </table> </td> <td> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> </tr> </table> </td> </tr> </table>	Original Licensure State and License Number	Original Issue Date	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:40px; height: 20px;"> </td> </tr> <tr> <td align="center" style="font-size: 8px;">State</td> <td></td> <td align="center" style="font-size: 8px;">License Number</td> </tr> </table>				State		License Number	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> <td style="width:20px; height: 20px;"> </td> </tr> </table>						
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<p>11. Nursing Licensure</p> <p>List all states or countries in which you are now, or ever have been licensed to practice as an APRN</p> <p>NOTE: Please indicate the current <u>license type</u> and <u>status</u> of each entry.</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">State/Country:</th> <th style="width:30%;">License Type (APRN)</th> <th style="width:40%;">Status</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> </tbody> </table>	State/Country:	License Type (APRN)	Status	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
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<p>12. Criminal Convictions</p> <p>Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.</p> <p>If necessary, you may continue on a separate 8½ x 11 sheet of paper.</p>	<p>Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Abbreviation of State and Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance):</p> <table style="width:100%;"> <tr> <td style="width:80%;">_____</td> <td style="width:10%; text-align: center;">Month</td> <td style="width:10%; text-align: center;">Year</td> </tr> <tr> <td>_____</td> <td align="center"><table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table></td> <td align="center"><table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table></td> </tr> <tr> <td>_____</td> <td align="center"><table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table></td> <td align="center"><table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table></td> </tr> <tr> <td>_____</td> <td align="center"><table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table></td> <td align="center"><table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table></td> </tr> </table>	_____	Month	Year	_____	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>			<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>			_____	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>			<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>			_____	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>			<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>		
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13. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

1. Are there any charges or investigations pending, in any state, against you? Yes No

2. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? Yes No

3. Have you ever had any disciplinary action(s) taken, or is any pending against your license to practice nursing, or any other licenses, registrations or certifications that you hold; or are any complaints pending in any state? Yes No

Note: If you answered "yes" to any of these questions you must submit a written explanation sheet of paper.

14. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Nurse Registration and Nursing Education any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as nurse in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Nurse Registration and Nursing Education of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)



Rhode Island Board of Nurse Registration and Nursing Education

Room 103, Three Capitol Hill

Providence, RI 02908-5097

(401) 222-5700

Substitute forms are not acceptable - This form may be duplicated as needed.

INTERSTATE VERIFICATION FORM - ALL STATES OF LICENSURE

I am applying for a license to practice as an APRN in the State of Rhode Island. The Rhode Island Board of Nurse Registration and Nursing Education requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Nurse Registration and Nursing Education at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE NURSING BOARD

Basis for Issuing License:

APRN

Licensed by:

Endorsement Exam

License Status:

Active Inactive Lapsed

Original Date Issued:

Expiration Date:

Questions:

- Has this registered nurse ever been investigated by your Board? Yes No
- Has this registered nurse incurred any disciplinary proceedings in your state, or is any action pending? Yes No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
- Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____



Please return directly to the Board at the above address. Thank you for your prompt cooperation.



Rhode Island Board of Nurse Registration and Nursing Education

Room 103, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-5700

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniformed Controlled Substances Act Registration (CSR). **I understand that there is an additional \$200.00 fee for this Registration and that the check or money order must be made out to the RI General Treasurer.**

Print/Type Full Name _____	Rhode Island Business Name _____	Current RI NPP/PCNS License No. _____
Signature _____	Rhode Island Business Address _____	Business Telephone _____
Date _____		Business Fax _____

Complete this application for registration to prescribe controlled substances in the State of Rhode Island	The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site: www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm
	Drug Schedule (Check all that apply) <input type="checkbox"/> Schedule II <input type="checkbox"/> Schedule III <input type="checkbox"/> Schedule IV <input type="checkbox"/> Schedule V
A CSR is not required if there will be no controlled substances prescriptions prescribed in this state. The CSR is renewed at the same time that the professional license is renewed. NOTE: Read Important Information on the bottom of this application.	<p>A Copy of the DEA Registration must be provided to the Nursing Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*</p> <p>All Applicants MUST answer the following:</p> <p>A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered "Yes" to question "A" or "B" attach an explanation to this form.</p>

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID". Licensed drug facilities and licensed practitioners with prescriptive privileges, cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: www.dea diversion.usdoj.gov/drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more than one hundred (100) dosage units and not more than one hundred (100) dosage units maybe dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.