



State of New Mexico Board of Nursing
6301 Indian School Rd NE, Suite 710
Albuquerque, NM 87110

AFFIDAVIT REQUESTING PRESCRIPTIVE AUTHORITY

Verification of practice as an APRN

APRN's Registered Nurse License# _____ State _____ Expiration Date _____

New Mexico CRNA, CNP, CNS License # _____

I hereby certify that I have Practiced as an APRN since _____ (enter date)

I hereby certify that I have practiced as a: ___ CNP ___ CNS ___ CRNA (check one) and obtained the required prescribing clinical hours in the State of: _____ APRN License # _____

Prescriptive Authority

You must initial the appropriate statement(s)

_____ I wish to apply for permission to prescribe dangerous drugs.

Initial

_____ I have at least 400 clinical hours in the previous 2 years during which I prescribed medication.

Initial

_____ I wish to apply for permission to prescribe controlled substances.

Initial

OR

_____ I have not fulfilled the above requirements. I will complete 400 hours of prescribing dangerous drugs in a preceptorship with a licensed CNP, CNS, CRNA or physician. The preceptorship must be completed within six (6) months and a letter of authorization will be issued for the duration of the preceptorship.

Initial

Printed Name

Signature

STATE OF (_____) SS

County of _____)

I hereby certify that _____ has signed in my presence.

Type or Print Name

On this _____ day of _____
DD MM YYYY

Notary Public

Seal:

My Commission Expires: _____