



MISSOURI
State Board of Nursing

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
PRESCRIPTION IDENTIFICATION FORM

MAILING ADDRESS:
STATE BOARD OF NURSING
ATTN: DIRECTOR OF COMPLIANCE
PO BOX 656
JEFFERSON CITY, MO 65102-0656
Fax: 573-522-2143
Email: nursingcompliance@pr.mo.gov

INSTRUCTIONS

Instructions:

1. This form must be completed, in full, by the Licensee's **Primary Care Provider (PCP)**.
2. Licensee is responsible for making sure the prescriber provides this completed form to the Missouri Board of Nursing within five (5) business days of the prescription date.
3. Contact the Director of Compliance with questions at nursingcompliance@pr.mo.gov

LICENSEE INFORMATION

Name of Licensee/Patient	License number
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Participant in:

- Alternative Program Intervention Program Probationary Licensee Not Currently in a Board Program

I acknowledge the participant has explained to me that he/she is being monitored by the Board related to the following substances:

1. _____ 2. _____ 3. _____ 4. _____

PRESCRIPTION INFORMATION

DATE OF PRESCRIPTION	NAME OF MEDICATION	DOSAGE AND FREQUENCY	AMOUNT PRESCRIBED	NUMBER OF REFILLS	QUALIFYING DIAGNOSIS/CONDITION	CONTROLLED SUBSTANCE?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

For controlled substances, indicate the length of time the medication is to be used:

Date prescription should be disposed or completed:

It is recommended that a licensee receive no more than a one-month supply of any controlled medication in a single prescription. A Prescription Identification Form must be completed with each refill.

AUTHORIZATION FOR MARIJUANA USE

DATE AUTHORIZED	FREQUENCY OF USE	QUALIFYING MEDICAL CONDITION

METHOD OF INGESTION

- Edibles Vaping Smoking Capsules Topicals Other: _____

PCP AFFIRMATION

Please initial next to each statement and sign below to confirm the following:

- _____ I have reviewed the agreement/order between the patient and the Missouri State Board of Nursing.
- _____ I am an active, licensed physician (MD or DO) or authorized practitioner who is actively managing the underlying qualifying medical condition/s.
- _____ The Licensee has a specific qualifying medical condition that supports the prescriptions and/or marijuana as an active, recommended component of the licensee's medical treatment plan.

_____ I acknowledge I have reviewed Licensee's current nursing job description and fully comprehends the safety-sensitive nature, critical thinking demands, and physical requirements of the Licensee's specific role.
-OR-
_____ Licensee reported not working in a healthcare position

_____ **REQUIRED IF PRESCRIBING CONTROLLED SUBSTANCES** – Based on a reasonable degree of medical certainty, I attest the Licensee's recommended use of controlled substance/s **will not impair** Licensee's ability to safely, competently, and effectively practice nursing.

_____ **REQUIRED IF AUTHORIZING THE USE OF MARIJUANA** – Based on a reasonable degree of medical certainty, I attest the Licensee's recommended use of marijuana, **will not impair** Licensee's ability to safely, competently, and effectively practice nursing.

_____ I agree to promptly notify the Board if the Licensee's medical condition deteriorates, if the dosage/frequency of use escalates to a level that introduces a risk of impairment, or if I can no longer confidently certify the Licensee is safe to practice.

Authorized Provider's Signature	Date
Authorized Provider's Name & Credentials	Office Phone Number
Facility Name	Fax Number
Office Address	

ORIGINAL MUST BE RETURNED BY PCP