



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE METRO CENTER  
NASHVILLE, TENNESSEE 37243

NOTICE AND FORMULARY  
(800) 778-4123, ext. 11398 or (615) 532-3202, ext. 11398

TENNESSEE BOARD OF NURSING  
ADVANCED PRACTICE NURSE

**AUTHORIZATION FOR PRESCRIBING ADVANCED PRACTICE NURSE**

Advanced Practice Nurse Name \_\_\_\_\_

TN/Multi-state Registered Nurse Number \_\_\_\_\_

TN Advanced Practice Number \_\_\_\_\_

Advanced Practice Nurse DEA Number \_\_\_\_\_

**Name of Practice/Clinic** \_\_\_\_\_

Address \_\_\_\_\_

City

State

Zip Code

Work Phone Number \_\_\_\_\_

**PLEASE DELETE:**

**Delete Name/Clinic** \_\_\_\_\_

**Delete Supervising Physician(s)** \_\_\_\_\_

**PLEASE ADD:**

**Add Supervising Physician(s)** \_\_\_\_\_

**ADVANCED PRACTICE NURSE**

**This section must be completed by the supervising physician(s).  
(This page may be duplicated if necessary)**

**List all practice settings:**

**1) Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
DEA Number

**2) Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
DEA Number

**3) Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
DEA Number

**4) Setting:**

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
DEA Number

I, \_\_\_\_\_ MD/DO, License Number \_\_\_\_\_  
Signature

I, \_\_\_\_\_ MD/DO, License Number \_\_\_\_\_  
Signature

I, \_\_\_\_\_ MD/DO, License Number \_\_\_\_\_  
Signature

I, \_\_\_\_\_ MD/DO, License Number \_\_\_\_\_  
Signature

do hereby delegate the above prescribing authority to \_\_\_\_\_ APN of whom I  
am the supervising physician and will assume the responsibility according to TCA §63-7-123.

I, \_\_\_\_\_ APN do hereby accept the delegated function of prescribing  
authorization and will utilize it as such according to TCA §63-7-123.

\_\_\_\_\_  
Signature of Advanced Practice Nurse

\_\_\_\_\_  
Date

Check the classification of drugs authorized to prescribe:

- |  |   |
|--|---|
| <input type="checkbox"/> Analgesics                          | <input type="checkbox"/> Electrolytic, Caloric & Water Balance  |
| <input type="checkbox"/> Anesthetics                         | <input type="checkbox"/> Enzymes                                |
| <input type="checkbox"/> Antihistamines                      | <input type="checkbox"/> Expectorants and Cough Preparations    |
| <input type="checkbox"/> Antihypertensive                    | <input type="checkbox"/> Eye, Ear, Nose and Throat Preparations |
| <input type="checkbox"/> Anti-infective Agents               | <input type="checkbox"/> Gastrointestinal Drugs                 |
| <input type="checkbox"/> Anti-inflammatory Agents            | <input type="checkbox"/> Hormones and Synthetic Substitutes     |
| <input type="checkbox"/> Anti-neoplastic Agents              | <input type="checkbox"/> Hyperglycemic Agents                   |
| <input type="checkbox"/> Antispasmodics and Anticholinergics | <input type="checkbox"/> Migraine Preparations                  |
| <input type="checkbox"/> Antivirals                          | <input type="checkbox"/> Muscle Relaxant Preparations           |
| <input type="checkbox"/> Arthritis Medications               | <input type="checkbox"/> Narcotic Antagonists                   |
| <input type="checkbox"/> Autonomic Drugs                     | <input type="checkbox"/> Oxytocics                              |
| <input type="checkbox"/> Blood Derivatives                   | <input type="checkbox"/> Psychotropics                          |
| <input type="checkbox"/> Blood Formation and Coagulation     | <input type="checkbox"/> Serum, Toxoids, and Vaccine            |
| <input type="checkbox"/> Birth Control Drugs and Devices     | <input type="checkbox"/> Skin and Mucous Membrane Preparations  |
| <input type="checkbox"/> Bronchodilators/Anti-asthma Drugs   | <input type="checkbox"/> Smoking Cessation Aids                 |
| <input type="checkbox"/> Cardiovascular Drugs                | <input type="checkbox"/> Smooth Muscle Relaxants                |
| <input type="checkbox"/> Central Nervous system Drugs        | <input type="checkbox"/> Spasmolytic Agents                     |
| <input type="checkbox"/> Contraceptives                      | <input type="checkbox"/> Sympathomimetics and Combination       |
| <input type="checkbox"/> Diabetic Agents                     | <input type="checkbox"/> Vitamins                               |
| <input type="checkbox"/> Diagnostic Agents                   | <input type="checkbox"/> Schedule II                            |
| <input type="checkbox"/> Decongestants                       | <input type="checkbox"/> Schedule III                           |
|  | <input type="checkbox"/> Schedule IV                            |
|  | <input type="checkbox"/> Schedule V                             |

**PLEASE RETURN ORIGINAL BY MAIL TO: (DO NOT FAX)**

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NASHVILLE, TN 37243**

**PLEASE NOTE: DO NOT COMPLETE A NEW PROFILE FOR CHANGES IN SUPERVISING PHYSICIAN(S).  
MANDATORY PRACTITIONER PROFILE WILL BE UPDATED BASED ON RECEIPT OF THIS NOTICE  
FORMULARY**