



**CERTIFICATE TO PRESCRIBE EXTERNSHIP (CTP-E)(500 HOURS)
APPLICATION INSTRUCTIONS**

Complete this application if the following applies:

You have/had authority in another state/jurisdiction to prescribe drugs and therapeutic devices, excluding controlled substances for 1 continuous year within the past 3 years.

Eligibility for a CTP-E requires the possession of a current, valid Ohio RN license and a Certificate of Authority (COA) to practice as a Certified Nurse-Midwife (CNM), Certified Nurse Practitioner (CNP) or Clinical Nurse Specialist (CNS).

Steps to obtain an Ohio CTP-E:

1. Completed CTP-E application.

Please complete in ink or typed print. Please print legibly. If any part of this application is incomplete, the application may be returned.

2. Non-refundable Application Fee

A **\$50 non-refundable fee** payable to "Treasurer, State of Ohio" must accompany this application. Send a certified check, cashier's check or money order. Personal checks or cash will not be accepted. Business checks from government entities, corporations, and education or training programs will be accepted. Payments must be drawn on a United States (U.S.) bank payable in U.S. dollars. Please do not staple your payment to the application. If the submitted fee does not meet the requirements, the entire application will be returned to you.

3. Verification of prescriptive authority in another state/jurisdiction.

Complete the first page of **Form A** and forward both pages to the other jurisdiction or federal government to provide verification of your prescriptive authority.



FAQs

Can I submit the COA and CTP-E applications together?

Yes, however you are not eligible for a CTP-E until your COA has been issued. You cannot combine the fees when you send in multiple applications. Each application requires a separate payment.

Can I submit the CTP-E application before I have my collaborating Physician/Podiatrist information?

Yes, the CTP-E application can be submitted without the collaborating physician/podiatrist information. However, the CTP-E cannot be issued until you send (by email, fax or letter) this information to the Board. Applications are maintained on file for one year.

How do I know you received my application?

Please go to the Board's website at www.nursing.ohio.gov, click on "verification" and enter your name. Once your name appears, it will display as "pending" until a CTP-E is issued. If any part of this application is incomplete, the application may be returned. If the application remains incomplete for one year, the application will be considered void and the fee will be forfeited.

When can I start prescribing?

You may not prescribe until your CTP-E is issued. The CTP-E cannot be issued without the collaborating physician/podiatrist information. The CTP-E must have a five-digit number, an expiration date and a status of "active" on the Board's verification system before you may prescribe.

How do I renew my CTP-E?

The CTP-E is initially issued for one year. An externship cannot be renewed, but it can be extended. A request for an extension may be made by email, fax or letter before the CTP-E expires. There is no fee and the CTP-E will be extended two additional years.

What if my CTP-E expires? Am I able to prescribe?

Prescribing when the CTP-E is expired is a felony, and you may be subject to Board discipline.

How do I complete my externship and receive my CTP?

After the 500 direct hours have been completed, Form B must be submitted by the collaborating physician's/podiatrist's office directly to the Board by email, fax, or letter in order to receive your CTP.

What is the purpose of the externship?

"Externship" means the practice relationship, consistent with the standard care arrangement, between a nurse who holds a current, valid externship certificate to prescribe and one or more licensed physicians during which time the nurse's prescribing activities are reviewed and evaluated by a supervising professional for the purpose of ongoing improvement of the nurse's competence, knowledge, and skill in pharmacokinetic principles and the application of these principles to the nurse's area of practice. The standard care arrangement entered into between the collaborating physician and the nurse shall specify the frequency of the review needed for appropriate oversight.

How many hours do I need to obtain?

You must complete a total of 500 direct hours.

What does direct supervision mean?

Direct supervision means the supervising professional is available on site. At the discretion of the collaborating physician, a nurse with prescriptive authority may provide up to 200 hours of direct supervision, provided the nurse is a current prescribing COA holder with a CTP (not a CTP-E).

When can I apply for my DEA number?

You can apply for a DEA number(s) once you receive your CTP-E. Notify us (by email, fax or letter) of your DEA number when it is issued and when additions or deletions occur. Please note that the Board does not issue DEA numbers. For information on obtaining a DEA number, access the DEA website at <http://www.deadiversion.usdoj.gov>. If you are authorized to use a hospital's DEA number, please be sure to provide the entire DEA number, including your uniquely assigned 3 or 4-digit suffix (example: BH1234567-0123).

Do I need to register with OARRS?

CTP holders who hold appropriate DEA certification and prescribe opioid analgesics or benzodiazepines are required to be registered with OARRS. To register for OARRS, go to <http://www.ohiopmp.gov>.



CERTIFICATE TO PRESCRIBE EXTERNSHIP (CTP-E) APPLICATION (500 HOURS)

Mail application and fee to address above, attention: APRN Unit

\$50 fee made payable to "Treasurer, State of Ohio" submitted in the form of a:

- Payment options: Certified Check, Cashier's Check, Money Order, Business check from government entity/corporation/education/training program. Note: Personal checks are not accepted by the Board.

Ohio COA# (may leave blank if COA has not been issued yet)

Full Legal Name (Last, First, Middle, Maiden)

Social Security Number*

Address City

State Zip County

Telephone# Email

MILITARY (check if applicable)

- Military status options: I am a member or former member of the armed forces... I am the spouse of a member or former member of the armed forces...

OHIO COLLABORATING PHYSICIAN/PODIATRIST INFORMATION

(Note: The CTP-E application may be submitted before you have this information, but the CTP-E cannot be issued until this information is received)

Attach a separate sheet if needed.

Name (first and last)

Business Address (include city, state and zip code)

Name (first and last)

Business Address (include city, state and zip code)

*Your social security number is required by state and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the National Practitioner Data Bank (Public Law 100-93, Sec. 1921 of the Social Security Act, as amended; 45 C.F.R. pt. 60); reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

PRESCRIPTIVE AUTHORITY HISTORY

List the state(s) in which you hold/held prescriptive authority to prescribe drugs and therapeutic devices, excluding controlled substances. Attach a separate sheet if needed.

STATE	LICENSE/CERTIFICATE NUMBER	ISSUE DATE	EXPIRATION DATE

I am or have been employed by the U.S. Government: Yes No

COMPLIANCE (Application will be returned if any question is left unanswered)

Please circle "Yes" or "No" to each question. Your application **is not** complete until the Board has received **ALL** required documents.

CAUTION: False, and/or misleading information provided by an applicant may result in the denial/permanent denial of a nursing license/certificate.

For questions 1a and 1b have you EVER been convicted of, found guilty of, pled guilty to, pled no contest to, pled not guilty by reason of insanity to, entered an Alford plea, received treatment or intervention in lieu of conviction, or been found eligible for pretrial diversion or a similar program for any of the following crimes? This includes crimes that have been expunged IF there is a direct and substantial relationship to nursing practice.		
1a	A felony in Ohio, another state, commonwealth, territory, province or country? <i>If you answer "Yes", enter the court and case number.</i> Court Name: _____ Case#: _____	Yes No
1b	A misdemeanor in Ohio, another state, commonwealth, territory, province, or country? This does not include traffic violations unless they are DUI/OVI or Physical Control While Under the Influence. <i>If you answer "Yes", enter the court and case number.</i> Court Name: _____ Case#: _____	Yes No
2.	Has any board, bureau, department, agency or other body, including those in Ohio, other than this Board, in any way limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you; placed you on probation, or imposed a fine, censure or reprimand against you? Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate, or registration?	Yes No
3.	Have you ever, for any reason, been denied an application, issuance or renewal for licensure, certification, registration, or the privilege of taking an examination, in any state (including Ohio), commonwealth, territory, province, or country?	Yes No
4.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, certificate, or registration in lieu of or in order to avoid formal disciplinary action, with any other board, bureau, department, agency, or other body, including those in Ohio, other than this Board?	Yes No
5.	Have you been notified of any current investigation of you, or have you ever been notified of any formal charges, allegations, or complaints filed against you by any board, bureau, department, agency, or other body, including those in Ohio, other than this Board, with respect to a professional license, certificate, or registration?	Yes No
6.	Are you required to register, under Ohio Law, the law of another state, the U.S., or a foreign country, as a sex offender?	Yes No

If you answer, "Yes" to any of the questions 1-6, you are required to provide the Board with a written explanation of the events including the date, county, and state in which the events occurred and a certified copy of documents from the court or acting body. Your application is not complete until you have submitted these documents.

Last Name

First Name

Middle

(Print clearly, your full legal name as it appears on the first page of the application)

Certificate to Prescribe Externship Attestation

I am the person in this application for Certificate to Prescribe Externship and the statements made herein are true.

I am aware that misrepresentation on this application may result in disciplinary action in accordance with Section 4723.28 of the Revised Code. I attest that the information provided on this application is true.

I hereby request that in order to process my application, act upon renewal requests, and respond to public requests to confirm my license/certificate status, my personal information be accessed in accordance with OAC 4723-1-11 (D)(2)(d)(ii).

Printed Legal Name of Applicant

(Application will be returned if name is not printed)

Legal Signature of Applicant

(Application will be returned if name is not signed)

THIS SIDE BOARD USE ONLY

ITEMS RECEIVED

- Active RN
- COA
- Collaborator information
- Form A

NOTES _____



FORM A

VERIFICATION OF PRESCRIPTIVE AUTHORITY
NOT AUTHORIZED to Prescribe Controlled Substances

APPLICANT: Please complete and forward to the state (any jurisdiction of the National Council of Nursing) or to the place of employment within the U.S. Government where you hold/held valid authority and therapeutic devices, excluding controlled substances, for a continuous period of at least one year dur immediately preceding the date of the CTP application. Contact the verifying state for fee information.

Name (Last) (First) (Middle) (M

Social Security Number* Date of Birth

Address

City State Zip

STATE LICENSURE INFORMATION

License/Certificate # Issue Date Expiration Date

Name under which license/certificate was issued (Last) (First)

U.S. GOVERNMENT EMPLOYMENT INFORMATION

U.S. Government Agency (Identify branch of service, federal installation or Veterans' Administration Employme

Employment Dates From (Month) (Year) To (Month)

I hereby authorize the (please list state) State Board of Nursing or the U.S. Gove the Ohio Board of Nursing with the information requested in Part 2.

Signature Date

*Your social security number is required by state and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the National Practi Law 100-93, Sec. 1921 of the Social Security Act, as amended; 45 C.F.R. pt. 60); reporting to law enforcement authorities for investigative/law enforcement purposes in complianc reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

BOARD OF NURSING OR U.S. GOVERNMENT REPRESENTATIVE: Please complete the sections below and mail directly to the Board.

Ohio Board of Nursing
Attn: APRN Unit
17 South High Street, Suite 400
Columbus, OH 43215-7410

Name of Nurse _____

License/Certificate # _____ Issue Date _____ Expiration Date _____

Current license/certificate status: Active Inactive Lapsed

Does this nurse have authority to prescribe drugs and therapeutic devices, excluding controlled substances? Yes No

Is there any pending disciplinary action against this license/certificate? Yes (If yes, attach explanation) No

Has this license/certificate ever been encumbered (revoked, suspended, surrendered, restricted, limited, placed on probation, etc.)? Yes (If yes, attach explanation) No

THIS SECTION IS TO BE COMPLETED BY THE STATE BOARD OF NURSING REPRESENTATIVE

I certify that the above information accurately represents the information on file with the State Board of Nursing, for the above named nurse.

Signed and the State Board of Nursing seal affixed this _____ day of _____, 20_____.

Signature _____ Title _____ State _____

(STATE SEAL)

THIS SECTION IS TO BE COMPLETED BY THE U.S. GOVERNMENT REPRESENTATIVE

I certify that the above information accurately represents the information on file with

_____, for the above named nurse.

(Identify branch of service, federal installation or Veterans' Administration employment)

Signature of U.S. Government Employer _____ Date _____

Printed Name _____



FORM B

(Application for CTP after Completion of 500 Externship Hours)

- After completing the 500 direct hours, the collaborating physician or podiatrist's office must send Form B directly to the Board via email (aprn@nursing.ohio.gov), fax (614-466-0388 Attn: APRN), or mail (see address above, ATTN: APRN). The Board will not accept this form from the applicant.
• Each collaborating physician/podiatrist may complete a form, or it may be completed by one physician/podiatrist within a group/practice
• No fee is required when submitting this form
• Submit certificates of completion for two (2) contact hours on Ohio laws governing drugs and prescriptive authority with this form. Contact aprn@nursing.ohio.gov for approved courses.

CTP APPLICANT:

Full Legal Name (Last) (First) (Middle) (Maiden)

CTP-E # Email

Signature Date

PHYSICIAN/PODIATRIST COLLABORATOR:

I certify that the above named individual completed direct prescribing hours within the following dates of their externship.

PRESCRIBING START DATE (month/year)

PRESCRIBING END DATE (month/year)

DIRECT SUPERVISION HOURS

Printed Name Signature

Ohio Medical License # Business Address

CTP COLLABORATOR:

I certify that the above named individual completed direct prescribing hours within the dates of their externship. (Up to 200 hours)

DIRECT HOURS Ohio CTP #

Printed Name Signature