



## CERTIFICATE TO PRESCRIBE (CTP) APPLICATION INSTRUCTIONS

### Complete this application if:

**You have/had authority in another state/jurisdiction to prescribe drugs and therapeutic devices including at least some controlled substances for at least 1 continuous year within the past 3 years.**

Eligibility for a CTP 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:

##### 1. Completed CTP 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.

##### 4. Completion of two (2) contact hours in Ohio laws governing drugs and prescriptive authority.

Please contact [aprn@nursing.ohio.gov](mailto:aprn@nursing.ohio.gov) for information on Board approved courses.



## FAQs

### **Can I submit the COA and CTP applications together?**

Yes, however, you are not eligible for a CTP 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 application and receive my CTP before I have my collaborating Physician/Podiatrist information?**

Yes, the CTP application can be submitted and the CTP issued without the collaborating physician/podiatrist information. However, you must submit this (by email, fax or letter) within 30 days after first engaging in practice.

### **How do I know you received my application?**

Please go to the Board's website at [www.nursing.ohio.gov](http://www.nursing.ohio.gov), click on "verification" and enter your name. Once your name appears, it will display as "pending" until a CTP 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 is issued. The CTP must have a five-digit number, an expiration date and a status of "active" on the Board's verification system before you may prescribe.

### **What if my CTP lapses? Am I able to prescribe?**

Prescribing during a lapse in your CTP is a felony, and you may be subject to Board discipline.

### **When can I apply for my DEA number?**

You can apply for a DEA number(s) once you receive your CTP. **Notify us (by fax, email or letter) of your DEA number when it is issued and when any 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 (CTP) APPLICATION

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...

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...

OHIO COLLABORATING PHYSICIAN/PODIATRIST PRACTICE INFORMATION

(You may submit this information at a later date, but not later than thirty days after first engaging in practice)

Attach a separate sheet if needed.

Name

Business Address (include city, state and zip code)

Name

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...

**PRESCRIPTIVE AUTHORITY HISTORY**

List the state/jurisdiction in which you hold/held prescriptive authority to prescribe drugs and therapeutic devices, including at least some controlled substances for a continuous year within the past three years. 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 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 Attestation**

I am the person in this application for Certificate to Prescribe 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**

- Active RN**
- Active COA**
- 2 contact hours on Ohio prescribing**
- Form A**

**NOTES** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



FORM A

VERIFICATION OF PRESCRIPTIVE AUTHORITY

APPLICANT: Complete the first page of this form and then forward both pages to the state/jurisdiction of employment within the U.S. Government where you hold/held valid authority to prescribe drugs and the including at least some controlled substances. Before sending contact the state/jurisdiction for any fees inv

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

Social Security Number\* Date of Birth

Address

City State Zip

STATE/JURISDICTION LICENSURE INFORMATION

License/Certificate #

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 Employ

Employment Dates From (Month) (Year) to (Month) (Year)

I hereby authorize the (please list state/jurisdiction) Board of Nurs Federal Government to provide the Ohio Board of Nursing with the information requested on page 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/U.S. GOVERNMENT:** 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 APRN \_\_\_\_\_

License/Certificate # \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Licensure/Employment Dates: From \_\_\_\_\_ To \_\_\_\_\_  
(Month) (Year) (Month) (Year)

Current license/certificate status:  Active  Inactive  Lapsed

Has this nurse been given valid authority to prescribe drugs and therapeutic devices, including at least some 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 \_\_\_\_\_