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**VERIFICATION OF CRNA WRITTEN PRESCRIBING AGREEMENT FOR PURPOSES OF PROVIDING
 NONSURGICAL PAIN THERAPIES FOR CHRONIC PAIN SYMPTOMS**

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications prescribing nonsurgical pain therapies; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements. Minnesota Statute Sec. 270C.72 requires applicants to provide their Social Security number and Minnesota business identification number on all license applications.

All data submitted on this form, except social security number, is public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of approval. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

•Type or print clearly •Use black ink •Provide all information •Incomplete applications will be returned •Do not use initials or abbreviations

CRNA INFORMATION									
Certified Registered Nurse Anesthetists who will perform nonsurgical pain therapies for chronic pain symptoms must complete this form. The CRNA must have a written prescribing agreement with a physician licensed under Minnesota Statute Chapter 147, which defines the delegated responsibilities related to prescribing drugs and therapeutic devices within the scope of the agreement and the practice of the CRNA. The CRNA must perform the nonsurgical therapies at the same licensed health care facility as the physician.									
LAST NAME			FIRST NAME				MIDDLE NAME		
							<input type="checkbox"/> No middle name		
MAIDEN NAME			OTHER LAST NAME(S)			PHONE NUMBER <input type="checkbox"/> Home <input type="checkbox"/> Business			
						()			
STREET ADDRESS									
CITY			STATE/PROVINCE		ZIP/POSTAL CODE		COUNTRY		
EMAIL ADDRESS									
MINNESOTA LICENSE NUMBER					BIRTH DATE (mm/dd/yyyy)		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="checkbox"/> RN _____ <input type="checkbox"/> APRN _____									
UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72				<input type="checkbox"/> I do not have a US Social Security number at this time but will notify the Board if/when I obtain a US Social Security number			MINNESOTA BUSINESS IDENTIFICATION NUMBER Required by Minn. Stat. Sec. 270C.72		
			-						

VERIFICATION

The printed name, signature, license number of the CRNA and the licensed Minnesota physician, along with the date, must be provided. No other documents need to be filed with the Board of Nursing. Sign and date the form.

We have a written prescribing agreement that defines the delegated responsibilities related to prescribing drugs and therapeutic devices within the scope of the agreement and practice of the certified registered nurse anesthetist for the purpose of providing nonsurgical pain therapies for chronic pain symptoms.

<p>_____</p> <p>Printed Name _____ Date (mm/dd/yyyy) _____</p> <p>Certified Registered Nurse Anesthetist</p>	<p>_____</p> <p>Printed Name _____ Date (mm/dd/yyyy) _____</p> <p>Physician</p>
<p>_____</p> <p>Signature _____ Date (mm/dd/yyyy) _____</p> <p>Certified Registered Nurse Anesthetist</p> <p>License Number _____</p>	<p>_____</p> <p>Signature _____ Date (mm/dd/yyyy) _____</p> <p>Physician</p> <p>License Number _____</p>

I affirm that the statements and documents provided by me during the application process are true and correct.

Legal Signature of CRNA _____ Date (mm/dd/yyyy) _____

Return completed form to Minnesota Board of Nursing