ATTESTATION OF DEVELOPMENT OF ARTICULATED PLAN—FORM RXN-B

APPLICANT: Submit this form if your Prescriptive Authority was awarded after 7/1/2010 OR if you are applying for Prescriptive Authority to document completion of development of an articulated plan.

Return the completed form to: State Board of Nursing, 1560 Broadway, Suite 1350, Denver, CO 80202

LICENSEE INFORMATION

Name: Last:	First:	Middle:	Suffix:
Mailing Address: *This is a ☐ Home ☐ Business*	PO Box, Street: City, State, Zip:		
Daytime Telephone Number: ( )		**E-mail Address:** *Preferred method for communication: ☐ Mail ☐ E-mail*	
RN License Number:	**Advanced Practice Authority Number(s) :**	**Prescriptive Authority Number(s):** *(if applicable)*	

PART I—ATTESTATION—ADVANCED PRACTICE NURSE WITH PRESCRIPTIVE AUTHORITY

The Nurse Practice Act and the Colorado State Board of Nursing Chapter XV Rules require that Advanced Practice Nurses requesting Full Prescriptive Authority (RXN) develop an articulated plan for safe prescribing that documents how the advanced practice nurse intends to maintain ongoing collaboration with physicians and other health care professionals in connection with the advanced practice nurse's practice of prescribing medication within his or her role and population focus.

The Articulated Plan shall be retained by the RXN, shall be reviewed annually and appropriately updated, and shall be available to the State Board of Nursing upon request.

I state under penalty of perjury, as defined in C.R.S. 18-8-503, that by signing this Attestation, I have developed an articulated plan in compliance with the requirements of C.R.S. 12-38-111.6(4.5)(b)(II) and the State Board of Nursing Chapter XV Rules.

Signature _____ **Date** _____

PART II—ATTESTATION—PHYSICIAN or PHYSICIAN AND ADVANCED PRACTICE NURSE WITH PRESCRIPTIVE AUTHORITY

The development of the initial articulated plan may be attested to by a physician or an Advanced Practice Nurse with Prescriptive Authority (RXN).

I state under penalty of perjury, as defined in C.R.S. 18-8-503, that by signing this Attestation I assisted in the development of the initial articulated plan for the above-named Advanced Practice Nurse in compliance with the requirements of C.R.S. 12-36-106.4(2) and State Medical Board Rule 950.

Physician Signature _____ **License Number** _____ **Date** _____

I state under penalty of perjury, as defined in C.R.S. 18-8-503, that by signing this Attestation I assisted in the development of the initial articulated plan for the above-named Advanced Practice Nurse in compliance with the requirements of C.R.S. 12-38-111.6 and State Board of Nursing Chapter XV Rules.

RXN Signature (if applicable) _____ **License Number** _____ **Date** _____