ATTESTATION OF COMPLETION OF MUTUALLY STRUCTURED MENTORSHIP—FORM RXN-C

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 an 1800-hour mutually structured mentorship.

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) complete an 1800-hour mutually structured mentorship with a physician or a physician and an advanced practice nurse with prescriptive authority practicing in Colorado and whose practice corresponds with the role and population focus of the advanced practice nurse.

The mutually structured mentorship must be completed within the time frame specified in C.R.S. 12-38-111.6(4.5)(b)(I)(A).

I state under penalty of perjury, as defined in C.R.S. 18-8-503, that by signing this Attestation, I have completed _____ hours of a mutually structured mentorship in accordance with the requirements of C.R.S. 12-38-111.6(4.5)(b)(I) and State Board of Nursing Chapter XV Rules.

_____ _____

Signature **Date**

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

The completion of the mutually structured mentorship may be attested to by a physician or a physician and 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 participated in the mutually structured mentorship for the above-named Advanced Practice Nurse in compliance with the requirements of C.R.S. 12-36-106.4(1) 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 participated in the mutually structured mentorship for the above-named Advanced Practice Nurse in compliance with the requirements of C.R.S. 12-38-111.6(4.5)(b)(I) and State Board of Nursing Chapter XV Rules.

_____ _____

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