

User Guide for Certified Registered Nurse Practitioner (CRNP) Prescriptive Authority Collaborative Agreement Application

This guide provides step-by-step instructions for **Certified Registered Nurse Practitioners (CRNPs)** on how to submit a **Prescriptive Authority Collaborative Agreement** via the existing licensure application portal.

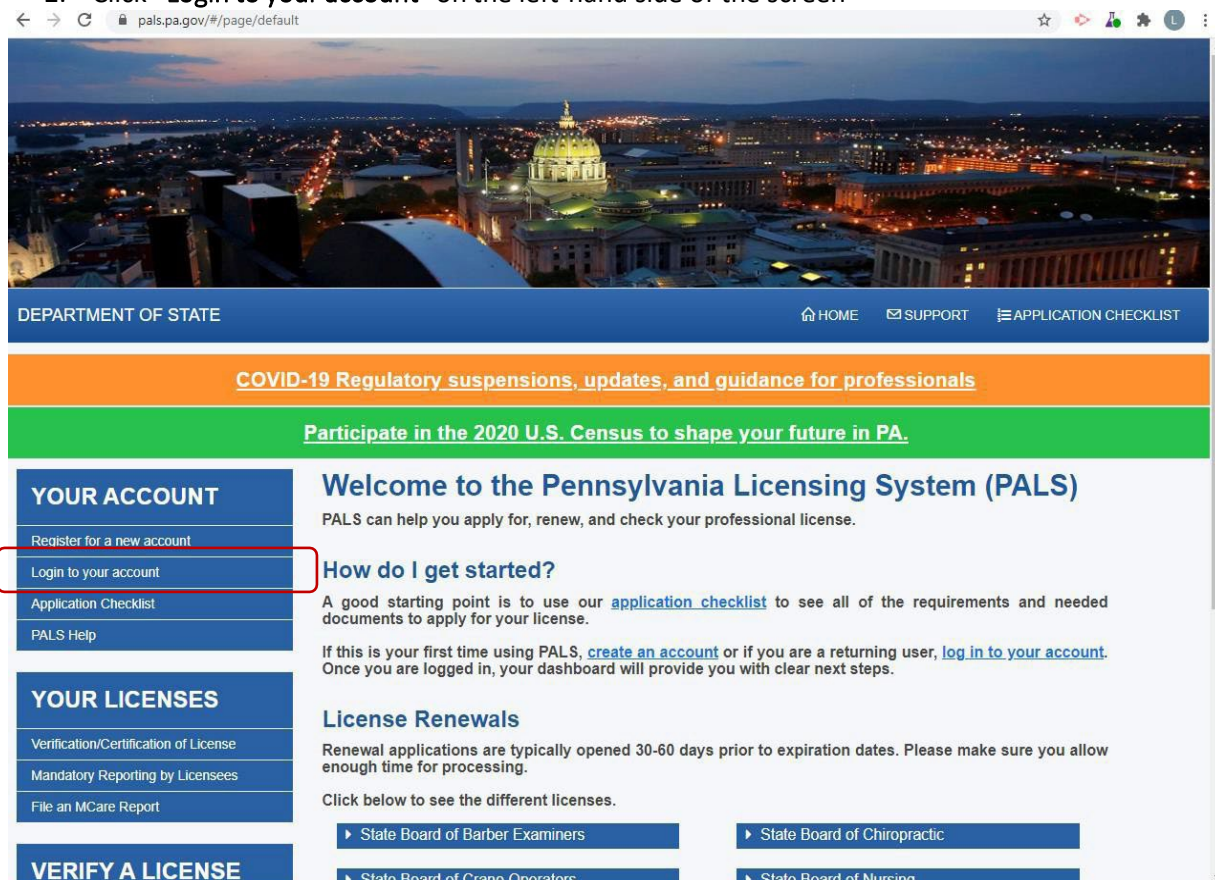
This process is required for CRNPs seeking prescriptive authority in collaboration with a licensed physician, in accordance with Pennsylvania Board of Nursing regulations.

Accessing the Portal

1. Go to the official licensure application portal:

👉 www.pals.pa.gov

2. Click “Login to your account” on the left-hand side of the screen




3. Enter your **existing credentials**:

- Username
- Password

4. Click **“LOGIN”**.

The screenshot shows a web browser window with the address bar displaying 'pals.pa.gov/#/page/login'. The page features a header with a night-time cityscape image and a navigation bar with links for 'HOME', 'SUPPORT', and 'APPLICATION CHECKLIST'. The main content area is titled 'Sign In for Existing Applicants & Licensees' and contains a login form. The form has two input fields: 'User ID' and 'Password'. The 'LOGIN' button is highlighted with a red rectangle. To the right of the form, there are several links for users who may not have an account or have forgotten their credentials: 'Don't have an account? Register Now', 'Forgot your User ID? Click here', 'Forgot your password? Reset here', 'Update your Email Address Click here', and 'Forgot your Registration code? Click here'. At the bottom of the form, there is a link for 'Need Assistance? Click here'. The footer of the page contains links for 'PRIVACY POLICY', 'SECURITY POLICY', 'AGENCIES', and 'CONTACT US', along with a copyright notice for 2020 Commonwealth of Pennsylvania.

 If you have forgotten your password, use the “Forgot Password” link to reset it.

Navigating to the Prescriptive Authority Application

1. After logging in, your **Dashboard** will appear.
2. Under "**Professional License Details**", locate your **CRNP** certification.
3. Click the "**Request**" button next to your certification.

Professional License Details

Link Facility Licenses Link Person Licenses

Change	License Number	E-License	Name	Board/Commission	License Type	Status	Issue Date	Expiration Date	Pre-Req
REQUEST	SP	Help	Download		Nursing	Certified Registered Nurse Practitioner(Neonatal)	Active	11/30/1987	4/30/2026
REQUEST	NPPA	Help	Download		Nursing	Prescriptive Authority(Neonatal)	Active	6/28/2018	4/30/2026
REQUEST	NPPA	Help	Download		Nursing	Prescriptive Authority(Neonatal)	Active	7/21/2020	4/30/2026
REQUEST	NPPA	Help	Download		Nursing	Prescriptive Authority(Neonatal)	Active	8/25/2023	4/30/2026
REQUEST	RNC	Help	Download		Nursing	Registered Nurse	Active (Single State)	9/5/1979	4/30/2026
REQUEST	NPPA	Help			Nursing	Prescriptive Authority	Agreement Terminated	10/16/2020	2/21/2024
REQUEST	NPPA	Help			Nursing	Prescriptive Authority(Neonatal)	Inactive	1/13/2015	4/30/2018

4. Select "**Prescriptive Authority**" options.

If this option is not visible, ensure your license status is active and you meet the eligibility requirements for prescriptive authority.

Change Options (License)

Verification/Certification Inactivate **Prescriptive Authority**

Entering Prescriptive Authority Collaborative Agreement Information

A checklist is available in the Application Instructions section detailing the necessary items for this application.

Application Instructions

Click on [i](#) for more information. To email or print the application checklist instruction [click here](#).

- Application [i](#)
- Application Fee [i](#)
- Opioid CE [i](#)
- Service Member [i](#)

The Applicant Information and Certified Registered Nurse Practitioner Information sections will be prepopulated.

APPLICANT INFORMATION:

Please complete all required fields. [Contact the Board Office](#) to complete a request for change of name. You must submit a copy of a legal document verifying the name as it is currently listed in the Board's records and also the new name.

[Click here to refresh personal information.](#)

Last Name	First Name	Middle Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth(MM/DD/YYYY)	Social Security Number		
<input type="text"/>	<input type="text"/>		
Street Address			
<input type="text"/>			
Address Line 2			
<input type="text"/>			
City	State	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
County	Country		
<input type="text"/>	<input type="text"/>		
Phone Number	Email		
<input type="text"/>	<input type="text"/>		
Maiden/Other Name			
<input type="text"/>			

CERTIFIED REGISTERED NURSE PRACTITIONER INFORMATION:


Name of Certified Registered Nurse Practitioner:	<input type="text"/>
Pennsylvania CRNP Certificate Number:	<input type="text"/>
CRNP specialty for this Collaborative Agreement for Prescriptive Authority:	Neonatal




NOTE: If CRNP has multiple specialties, ensure the specialty associated with this agreement is displayed.

You will be prompted to enter the following details:

- **Primary Collaborating Physician Medical License Number**
 - Physician must hold current Pennsylvania physician's license.
 - If the physician's license does not appear, double-check the license number for a possible change to a compact license.


PLEASE ENTER YOUR COLLABORATING PHYSICIAN:




 Please click here to search for a license.

LICENSE NUMBER	NAME	EXPIRATION DATE	EMAIL	CONFIRM EMAIL	
<input type="text"/>	<input type="text"/>	<input type="text" value="MM/dd/yyyy"/> 	<input type="text"/>	<input type="text"/>	
					

- **Substitute Physician(s) Full Name and Medical License Number**
 - Physician(s) must hold current Pennsylvania physician's license.
 - If the physician's license does not appear, double-check the license number for a possible change to a compact license.
 - Board of Nursing regulations state that at least one substitute physician be listed on the agreement (§21.285(a)(1)). Multiple substitute physicians may be listed if desired. Click the (+) sign at the lower right of the substitute physician section to enter additional physicians.

PLEASE ENTER YOUR SUBSTITUTE PHYSICIAN:

 Please click here to search for a license.

LICENSE NUMBER	NAME	EXPIRATION DATE		
<input type="text"/>	<input type="text"/>	<input type="text" value="MM/dd/yyyy"/> 		
				

- **Professional Liability Insurance**

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Professional Liability: Check one

☐ I maintain the required professional liability insurance.

☐ I am exempt from having the required professional liability insurance.

- **Circumstances and how often the collaborating physician will personally see the patient**

Indicate the circumstances, and how often the collaborating physician will personally see the patient. (Must check at least one.)

- | | |
|---|--|
| <input type="checkbox"/> CRNP Request | <input type="checkbox"/> Daily |
| <input type="checkbox"/> Every other visit | <input type="checkbox"/> Once per year |
| <input type="checkbox"/> Patient condition outside CRNP scope of practice | <input type="checkbox"/> Patient not responding to treatment |
| <input type="checkbox"/> Patient or Family request | <input type="checkbox"/> Twice per year |

- **Controlled Substances**

Controlled Substance Prescribing Authority: (Check YES or NO for each Schedule.)

Schedule II (Maximum 30 Day Supply)

☐ Yes ☐ No

Schedule III (Maximum 90 Day Supply)

☐ Yes ☐ No

Schedule IV (Maximum 90 Day Supply)

☐ Yes ☐ No

- **Categories of drugs from which the CRNP may prescribe or dispense**

Drug Categories: Individually check each category of drugs from which the CRNP may prescribe and dispense.

☐ (a) Antihistamines

☐ (c) Antineoplastic agents

☐ (e) Devices and pharmaceutical aids

☐ (g) Blood formation drugs

☐ (i) Thrombolytic and antithrombolytic agents

☐ (k) Central nervous system agents

☐ (m) Diagnostic agents

☐ (o) Electrolytic, caloric and water balance

☐ (q) Antitussive, expectorants and mucolytic agents

☐ (s) Local anesthetics

☐ (u) Serums, toxoids and vaccines

☐ (w) Smooth muscle relaxants

☐ (y) Hormones and synthetic substitutes

☐ (b) Anti-infective agents

☐ (d) Unclassified therapeutic agents

☐ (f) Autonomic drugs

☐ (h) Coagulation and anticoagulation drugs

☐ (j) Cardiovascular drugs

☐ (l) Contraceptives including foams and devices

☐ (n) Disinfectants for agents used on objects other than skin

☐ (p) Enzymes

☐ (r) Gastrointestinal drugs

☐ (t) Eye, ear, nose and throat preparations

☐ (v) Skin and mucous membrane agents

☐ (x) Vitamins

- **Effective date**

The date you are requesting that this agreement become effective:

MM/dd/yyyy



- **You must answer the service member question.**

Are you a servicemember, veteran, or military spouse?

☐ Yes ☐ No

- **Verification Statement Section:**
 - After reading each section, you must agree to the information by clicking on the box next to the confirmation statement.
 - You must type your name on the signature line to electronically sign the application.

VERIFICATION STATEMENT:

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards/Commissions to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards and commissions must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. Additionally, if applicable, Social Security Numbers are required in order for the Board/Commission to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

☒ I CONFIRM THAT I HAVE READ AND AGREE TO THE TERMS ABOVE.

Signature **Date**

Please type your name. 10/7/2025

- You will sign the “Certified Registered Nurse Practitioner Signature” section to agree to the terms of the prescriptive authority collaborative agreement:

CERTIFIED REGISTERED NURSE PRACTITIONER SIGNATURE:

This Collaborative Agreement for Prescriptive Authority contains the details regarding the prescribing and dispensing of drugs between the following parties:


Signature **Date**

Please type your name. 10/7/2025

- **Checklist Document Upload section:** This section is **not** mandatory if the CRNP has already provided the information.

Checklist Documents

Please upload the required documents for the checklist below.

Item	
<p>Opioid CE</p> <p>Section 9.1(a) of ABC-MAP* requires that all prescribers or dispensers, as defined in Section 3 of ABC-MAP, applying for licensure/approval complete at least 4 hours of Board-approved education consisting of 2 hours in pain management or the identification of addiction and 2 hours in the practices of prescribing or dispensing of opioids. Applicants seeking licensure/approval on or after July 1, 2017, must document, within one year from issuance of the licensure/ approval, that they completed this education either as part of an initial education program, a stand-alone course from a Board-approved course provider, or a continuing education course from an approved continuing education provider. The 4 hours of Board-approved education needs to be completed only once. See the Board's website for the Opioid Education Forms and additional information.</p> <p>*The Achieving Better Care by Monitoring All Prescriptions Program Act (ABC-MAP) (Act 191 of 2014, as amended) is available on the Legislature's website at: http://www.legis.state.pa.us/cfdocs/legis/Li/UsconsCheck.</p> <p>The Board's Regulations are available on the Board's website.</p>	<input type="text"/>  Browse

Save or Send to Physician

- Save allows you to save information and send it to the collaborating physician later.



- Click Send to Physician to send the agreement to the collaborating physician for review.



- Application will be listed as 'Pending Review' under the My Activities section of the CRNP Dashboard:

Activities (Showing Last 2 Years Activities) [Show more](#)

Click [here](#) to view the application checklist and upload required documents to your application. To upload documents, click the checklist item for the document you wish to upload. Under the "Check List Documents" header, click the Folder icon or "Multiple" button to browse your computer for the document. Once you have attached the document, click the blue "Upload" button. When all documents have been uploaded, click the "Submit" button.

Show 10 entries Search:

	Reference Number	Board/Commission	License Type	License Number	Description	Status	Timeline	Action
	AA000	Nursing	Prescriptive Authority		CRNP PRESCRIPTIVE AUTHORITY APPLICATION	Pending Review		
	AA00C	Nursing	Registered Nurse		RENEWAL APPLICATION	Completed		
	AA000	Nursing	Certified Registered Nurse Practitioner	SPI	RENEWAL APPLICATION	Completed		
	AA00C	Nursing	Prescriptive Authority	NPPA	RENEWAL APPLICATION	Completed		
	AA000	Nursing	Prescriptive Authority	NPPAI	RENEWAL APPLICATION	Completed		
	AA000	Nursing	Prescriptive Authority	NPPA	RENEWAL APPLICATION	Completed		
	AA00C	Nursing	Prescriptive Authority	NPPAI	INACTIVE REQUEST	Completed		

Showing 1 to 7 of 7 entries Previous 1 Next

Collaborating Physician Review of Agreement and Approval or Rejection

- The collaborating physician will receive an email notification that the agreement is pending their review.



- They will log in to their PALS account to access the application under their **My Queue** section:



- The red icon allows the collaborating physician to view the information.



- The blue button allows the collaborating physician to review the information then reject or approve the agreement.







Physician view of the agreement/application:

Note: The collaborating physician cannot make any edits to the agreement.

CRNP PRESCRIPTIVE AUTHORITY APPLICATION

Application Instructions

Click on  for more information. To email or print the application checklist instruction [click here](#).

- Application 
- Application Fee 
- Opioid CE 
- Service Member

APPLICANT INFORMATION:

Please complete all required fields. [Contact the Board Office](#) to complete a request for change of name. You must submit a copy of a legal document verifying the name as it is currently listed in the Board's records and also the new name.

APPLICANT INFORMATION:

Please complete all required fields. [Contact the Board Office](#) to complete a request for change of name. You must submit a copy of a legal document verifying the name as it is currently listed in the Board's records and also the new name.

Last Name

First Name

Middle Name

Suffix

Date of Birth(MM/DD/YYYY)

Social Security Number

Street Address

Address Line 2

City

State

Zip Code

County

Country

Phone Number

Email

Maiden/Other Name

CERTIFIED REGISTERED NURSE PRACTITIONER INFORMATION:

Name of Certified Registered Nurse Practitioner:

Pennsylvania CRNP Certificate Number:

SP

CRNP specialty for this Collaborative Agreement for Prescriptive Authority:

Neonatal **PLEASE ENTER YOUR COLLABORATING PHYSICIAN:** Please click here to search for a license.

LICENSE NUMBER	NAME	EXPIRATION DATE	EMAIL	CONFIRM EMAIL	
<input type="text" value="md"/>	<input type="text"/>	<input type="text" value="12/31/2026"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="X"/>
					<input type="button" value="+"/>

PLEASE ENTER YOUR SUBSTITUTE PHYSICIAN: Please click here to search for a license.

LICENSE NUMBER	NAME	EXPIRATION DATE	
<input type="text" value="md"/> C	<input type="text"/>	<input type="text" value="12/31/2026"/>	<input type="button" value="X"/>
			<input type="button" value="+"/>

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Professional Liability: Check one

- ☒ I maintain the required professional liability insurance.
- ☐ I am exempt from having the required professional liability insurance.

Indicate the circumstances, and how often the collaborating physician will personally see the patient. (Must check at least one.)

- ☒ CRNP Request ☐ Daily
- ☐ Every other visit ☐ Once per year
- ☒ Patient condition outside CRNP scope of practice ☒ Patient not responding to treatment
- ☒ Patient or Family request ☐ Twice per year

Controlled Substance Prescribing Authority: (Check YES or NO for each Schedule.)

Schedule II (Maximum 30 Day Supply)

☒ Yes ☐ No

I am requesting Schedule II for up to a day supply

Schedule III (Maximum 90 Day Supply)

☒ Yes ☐ No

I am requesting Schedule III for up to a day supply

Schedule IV (Maximum 90 Day Supply)

☒ Yes ☐ No

I am requesting Schedule IV for up to a day supply

Drug Categories: Individually check each category of drugs from which the CRNP may prescribe and dispense.

- | | |
|--|--|
| <input checked="" type="checkbox"/> (a) Antihistamines | <input checked="" type="checkbox"/> (b) Anti-infective agents |
| <input checked="" type="checkbox"/> (c) Antineoplastic agents | <input checked="" type="checkbox"/> (d) Unclassified therapeutic agents |
| <input checked="" type="checkbox"/> (e) Devices and pharmaceutical aids | <input checked="" type="checkbox"/> (f) Autonomic drugs |
| <input checked="" type="checkbox"/> (g) Blood formation drugs | <input checked="" type="checkbox"/> (h) Coagulation and anticoagulation drugs |
| <input checked="" type="checkbox"/> (i) Thrombolytic and antithrombolytic agents | <input checked="" type="checkbox"/> (j) Cardiovascular drugs |
| <input checked="" type="checkbox"/> (k) Central nervous system agents | <input checked="" type="checkbox"/> (l) Contraceptives including foams and devices |
| <input checked="" type="checkbox"/> (m) Diagnostic agents | <input checked="" type="checkbox"/> (n) Disinfectants for agents used on objects other than skin |
| <input checked="" type="checkbox"/> (o) Electrolytic, caloric and water balance | <input checked="" type="checkbox"/> (p) Enzymes |
| <input checked="" type="checkbox"/> (q) Antitussive, expectorants and mucolytic agents | <input checked="" type="checkbox"/> (r) Gastrointestinal drugs |
| <input checked="" type="checkbox"/> (s) Local anesthetics | <input checked="" type="checkbox"/> (t) Eye, ear, nose and throat preparations |
| <input checked="" type="checkbox"/> (u) Serums, toxoids and vaccines | <input checked="" type="checkbox"/> (v) Skin and mucous membrane agents |
| <input checked="" type="checkbox"/> (w) Smooth muscle relaxants | <input checked="" type="checkbox"/> (x) Vitamins |
| <input checked="" type="checkbox"/> (y) Hormones and synthetic substitutes | |

The date you are requesting this agreement become effective:

10/08/2025

Are you a servicemember, veteran, or military spouse?

☐ Yes ☒ No

VERIFICATION STATEMENT:

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards/Commissions to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards and commissions must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. Additionally, if applicable, Social Security Numbers are required in order for the Board/Commission to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

☒ I CONFIRM THAT I HAVE READ AND AGREE TO THE TERMS ABOVE.

Signature

Date

10/7/2025

CERTIFIED REGISTERED NURSE PRACTITIONER SIGNATURE:

This Collaborative Agreement for Prescriptive Authority contains the details regarding the prescribing and dispensing of drugs between the following parties:

Signature

Date

10/7/2025

Collaborating Physician Approval, Rejection or Save for later

- The Collaborating Physician must type their name on the signature line to electronically sign the application and click “Send to CRNP” to approve the agreement.

The screenshot shows a web form with three signature sections. The first section is titled "VERIFICATION STATEMENT:" and contains a notice about Social Security Number disclosure and a verification statement. Below this is a checkbox for "I CONFIRM THAT I HAVE READ AND AGREE TO THE TERMS ABOVE." The second section is titled "CERTIFIED REGISTERED NURSE PRACTITIONER SIGNATURE:" and contains a signature line and a date field set to 10/7/2025. The third section, which is highlighted with a red box, is titled "COLLABORATING PHYSICIAN SIGNATURE:" and contains a signature line with the placeholder text "Please type your name." and a date field set to 10/7/2025. At the bottom of the form, there are three buttons: "Save", "Reject", and "Send to CRNP", with the "Send to CRNP" button also highlighted with a red box.

VERIFICATION STATEMENT:

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards/Commissions to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards and commissions must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. Additionally, if applicable, Social Security Numbers are required in order for the Board/Commission to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911.1. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

☒ I CONFIRM THAT I HAVE READ AND AGREE TO THE TERMS ABOVE.

Signature _____ Date 10/7/2025

CERTIFIED REGISTERED NURSE PRACTITIONER SIGNATURE:

This Collaborative Agreement for Prescriptive Authority contains the details regarding the prescribing and dispensing of drugs between the following parties:

Signature _____ Date 10/7/2025

COLLABORATING PHYSICIAN SIGNATURE:

Signature _____ Please type your name. _____ Date 10/7/2025

Save Reject Send to CRNP

- Collaborating physician can also reject the agreement if there are changes to be made. Reject will send the information back to the CRNP to have the changes made.
- Save allows the collaborating physician to save information and reject or send to the CRNP later. Nothing will happen to the agreement/application. It will remain in Pending Review status on the CRNP dashboard.
- When the collaborating physician approves the application, the application will be sent back to the CRNP to complete the process for submission.

Application Completion and Submission

- You will receive an email notification when the agreement has been returned as approved or rejected.
- Rejected agreements will need to be worked out between you and the collaborating physician until all parties have reached an agreement.
- When the agreement has been approved by the collaborating physician, you will log in to your PALS Account to access the application under 'My Activities' or 'My Queue' section.

My Activities: Click on the blue link in the description column.

Activities (Showing Last 2 Years Activities) [Show more](#)

Click [here](#) to view the application checklist and upload required documents to your application. To upload documents, click the checklist item for the document you wish to upload. Under the "Check List Documents" header, click the Folder icon or "Multiple" button to browse your computer for the document. Once you have attached the document, click the blue "Upload" button. When all documents have been uploaded, click the "Submit" button.

Show entries Search:

Reference Number	Board/Commission	License Type	License Number	Description	Status	Timeline	Action
AA00C 📎	Nursing i	Prescriptive Authority		CRNP PRESCRIPTIVE AUTHORITY APPLICATION	Saved	↕	🗑️
AA000 📎	Nursing i	Registered Nurse	RN	RENEWAL APPLICATION	Completed	↕	
AA00C 📎	Nursing i	Certified Registered Nurse Practitioner	SP	RENEWAL APPLICATION	Completed	↕	
AA000 📎	Nursing i	Prescriptive Authority	NPPA	RENEWAL APPLICATION	Completed	↕	
AA00C 📎	Nursing i	Prescriptive Authority	NPPA	RENEWAL APPLICATION	Completed	↕	
AA00C 📎	Nursing i	Prescriptive Authority	NPPA	RENEWAL APPLICATION	Completed	↕	
AA000 📎	Nursing i	Prescriptive Authority	NPPA	INACTIVE REQUEST	Completed	↕	

Showing 1 to 7 of 7 entries Previous [1](#) Next

My Queue: Click on Review by CRNP.

My Queue

Show entries Search:

Description	Requested Date	Actions
CHANGE OF AGREEMENT - 📎 from 📎	09/01/2023	Review 📎
Review by CRNP - For CRNP PRESCRIPTIVE AUTHORITY APPLICATION from 📎	10/07/2025	Review by CRNP 📎

Showing 1 to 2 of 2 entries Previous [1](#) Next

- You will complete the application by answering the Legal Questions and providing and necessary documents.

PLEASE ANSWER THE FOLLOWING LEGAL QUESTIONS:

If you answer YES to any question below, you must upload complete details including a written explanation and copies of any relevant Board and/or legal documents. Please click UPLOAD after the file is selected to upload.

Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?

☐ Yes ☐ No

Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?

☐ Yes ☐ No

Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?

☐ Yes ☐ No

Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?

☐ Yes ☐ No

Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice (Nursing-Prescriptive Authority) in a competent, ethical, and professional manner?

☐ Yes ☐ No

Have you ever had your DEA registration denied, revoked or restricted?

☐ Yes ☐ No

Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?

☐ Yes ☐ No

Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?

☐ Yes ☐ No

Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?

☐ Yes ☐ No

- Submit the application by clicking the 'Submit' button.

Save

Submit

- You will be directed to review the application. Changes can only be made to the legal questions.
- An Add to Cart button will be available for payment either at the top or bottom of the page.

Top of page:

Review Your Application

You cannot make any changes to your application once it is submitted to the Board/Commission.

CRNP PRESCRIPTIVE AUTHORITY APPLICATION

Application Instructions

Click on [i](#) for more information To email or print the application checklist instruction [click here](#).

- Application [i](#)
- Application Fee [i](#)
- Opioid CE [i](#)
- Service Member

Add to Cart

Bottom of page:

The screenshot shows the bottom section of a web form. It contains two signature blocks. The first block is for a 'CERTIFIED REGISTERED NURSE PRACTITIONER SIGNATURE' and includes a text area for the signature and a date field set to '10/7/2025'. The second block is for a 'COLLABORATING PHYSICIAN SIGNATURE' and also includes a text area for the signature and a date field set to '10/7/2025'. Below these blocks is a red 'Add to Cart' button.

- You will be directed to your cart to submit payment.
- After successful payment, you will be directed to the payment confirmation page, where you can download a pdf copy of the application.
- The application will be submitted to the Board for review.
- You may **not** prescribe or dispense medication until your application has been approved.

Post-Submission Tracking

1. Return to your **Dashboard** to check the progress of your application.
2. Check the Activities section for the following statuses:
 - **Submitted**
 - **Needs Attention**
 - **Completed**
3. If additional information is required, you will be notified via **email**.

After approval, your prescriptive authority number will be generated, and the approval will be available for download on your dashboard.

A printable CRNP Prescriptive Authority Collaborative Agreement will be generated and available for download on the public verification site, www.pals.pa.gov/verify.

Prescriptive Authority Collaborative Agreements are required to be kept at the primary practice location and reviewed and updated at least once every 2 years or whenever the agreement is changed.