

State Board of Nursing

2525 N 7th Street

Harrisburg, PA 17110



BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

State Board of Nursing

P O BOX 2649

Harrisburg PA 17105-2649

VERIFICATION OF OPIOID EDUCATION

APPLICANT INFORMATION

NAME:	Last	First	Middle
OTHER NAME(S):			
DATE OF BIRTH:		LAST 4 DIGITS OF SSN:	
ADDRESS:			
CITY / STATE / ZIP:			

NP PROGRAM / ADVANCED PHARMACOLOGY COURSE PROVIDER / CE PROVIDER INFORMATION

NAME OF PROGRAM/PROVIDER:			
ADDRESS:			
CITY / STATE / ZIP:			
PRINT NAME OF DIRECTOR / PROVIDER:			
PHONE NUMBER:			
EMAIL ADDRESS OF DIRECTOR / PROVIDER:			

The following information must be completed by the Director of the NP Program, a Board-approved advanced pharmacology course provider, or the Board-approved continuing education provider and must verify that the applicant successfully completed at least 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids.

I hereby certify that the above-listed applicant successfully completed 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids on

____/____/____.

Month Day Year

I verify that the above statements are true and correct as validated by my review of the applicant's records. I verify that the information communicated on this form is true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsification to authorities.

Original Signature of Director / Provider:		DATE:	Month	Day	Year
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**RETURN THIS FORM TO THE STATE BOARD OF NURSING
VIA MAIL: PO BOX 2649, HARRISBURG, PA 17105
OR EMAIL: ST-NURSE@PA.GOV.**