College of Registered Nurses of Saskatchewan

NP Maintenance Prescriber Application
Prescribing Opioid Use Disorder (OUD) Drug Therapeutics and/or Methadone for Pain Management

Refer to CRNS Council Policy *Nurse Practitioner Scope of Practice Policy (2.7) (OUD/Methadone for Pain)* for prescribing approval requirements.

First Name _____ Middle Initial _____ Last Name_____

Date of Birth (DD/MMM/YYYY) _____ NP License # _____

Practice Location Specific to this Undertaking:_____

Address:_____

I am requesting prescribing approval for: OUD _____ Methadone for Pain _____ Both _____

Education

Course Name(s): _____

Completion Date(s): _____

Attach confirmation of completion to this form.

Practicum

Initiating Prescriber:_____

Practicum Location: _____

Date(s) of Practicum: _____

I certify that the information I have provided on this form is true and correct and acknowledge that my application for approval to prescribe OUD drug therapeutics and/or methadone for pain management may be refused or cancelled if I have provided any inaccurate information.

Email signed form to OUD@crns.ca

NP Signature:_____ Date: _____