College of Registered Nurses of Saskatchewan

NP Undertaking
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 _____

By signing below, I undertake to do the following:

- I am currently licensed as a practicing Nurse Practitioner and a member in good standing with the CRNS;
- My prescribing approval shall be indicated on the Register;
- I shall practice in accordance with current CRNS *Bylaws*, current *Council Policies*, current *Nurse Practitioner Practice Standards*; current *Nurse Practitioner Controlled Drugs and Substances Prescribing Guideline*; and current *Code of Ethics for Registered Nurses*; and;
- I will fully cooperate with such audits as required by the Registrar.

Email signed form to OUD@crns.ca

NP Signature: _____ Date _____

Witness: _____ Date _____

I acknowledge receipt of this undertaking:

Registrar: _____ Date _____

Witness: _____ Date _____