*(Must be on company or physician letterhead)*

# Form to Verify Hours of APRN Prescribing

**Documentation/Verification of the**
**Prescribing of Drugs, Medicines, and Therapeutic Devices**

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**TO: Arkansas State Board of Nursing, Advanced Practice Department**

I confirm that_____ , APRN, has completed _____ hours in the prescription of drugs, medicines, and therapeutic devices within the last year.

**Physician/APRN or**
**Clinic Representative Name & Title:_____**
*Printed name & title*

**Physician/APRN or**
**Clinic Representative Signature:_____**
*Signature*

**Date:_____**

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**AFFIDAVIT VERIFYING SIGNATURE (Above)**

**State of_____ County of _____**

**Sworn to before me this_____ day of _____ 20_____**

**My Commission Expires: _____**

**Notary Public Signature:_____**

**Notary Seal:**