(Must be on company or physician letterhead)

Verification of Prescribing Hours

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

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_____

AFFIDAVIT VERIFYING SIGNATURE (Above)

State of_____ **County of** _____

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

My Commission Expires: _____

Notary Public Signature:_____

Notary Seal: