State Board of Nursing
Advanced Practice Registered Nurse (APRN)
Notice of Existing Grant of Full Practice Authority in the Veterans Health Administration (VHA)

APRN's Name: ______________________

Please Select:

☐ CNP ☐ CNS ☐ CNM

List all states of licensure:

State: _____ License #: __________ Exp. Date: _______ DEA#: _______ Exp. Date: ______
State: _____ License #: __________ Exp. Date: _______ DEA#: _______ Exp. Date: ______
State: _____ License #: __________ Exp. Date: _______ DEA#: _______ Exp. Date: ______

1 VA facility: ______________________
Address: ____

2 VA facility: ______________________
Address: ____

3 VA facility: ______________________
Address: ____

Participates in Telehealth:

☐ Yes ☐ No

If *yes*, list the state(s) in which telehealth patients reside: ______________
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This document will serve to verify that I am employed by the Department of Veterans Affairs as a Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS), or Certified Nurse Midwife (CNM), who has been granted full practice authority under VA regulation 38 C.F.R. 17.415, Full practice authority for advanced practice registered nurses, and am therefore exempt from clinical supervision or mandatory collaboration of a physician when acting within the scope of my VA employment.

APRN Signature: ______________________ Date: __________
Credentials: ______________________

VA Service Chief Signature: ______________________ Date: __________