Nurse Practitioner Form 2C
Verification of Pharmacotherapeutics Course
(Three Semester Hours of the Equivalent)

The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Use this form ONLY if you have completed a program other than program registered by the New York State Education Department as qualifying for a certificate.

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for Certificate (Form 1). Be sure to sign and date item 8.
2. Send the entire form to the school/institution/professional association where you completed a pharmacotherapeutics course, including instruction in drug management of clients in the nurse practitioner's specialty area. Ask them to complete Section II and forward **both pages** of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required. **This form will not be accepted if submitted by the applicant or any party other than the school official.**

Section I - Applicant Information

1. Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)

2. Birth Date Month Day Year

3. New York State Registered Professional Nurse License Number

4. Print Your Name Exactly As It Appears On Your Application for a Certificate (Form 1)

Last

First

Middle

5. Mailing Address (You must notify the Department promptly of any address or name changes)

Line 1

Line 2

Line 3

City

State ZIP Code

Country/ Province

6. Print name under which course was completed (if different from above)

_____

7. Name of school/institution/professional association where course was completed _____

Address _____

8. I request and give my permission to the school/institution/professional association listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate.

_____ _____

Applicant's Signature Date

Section II - Verification of Completion of Pharmacotherapeutics Course

Instructions to School/Institution/Professional Association: Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of the form. **This form will not be accepted if returned by the applicant or any other party.**

1. It is hereby verified that _____
(see Section I, item 6)

has completed pharmacotherapeutics instruction in drug management of clients in the nurse practitioner's specialty area of

_____

2. This course was ☐ part of a nurse practitioner program, or

☐ supplementary course.

3. The inclusive date(s) of the course were ___ ___ ___ (mo. day yr.) and ___ ___ ___ (mo. day yr.)

4. The length of the course was _____ (semester hours) or _____ (clock hours)

5. In this course, did the individual named receive instruction in New York State and Federal laws relating to prescriptions and record keeping?

☐ Yes ☐ No

Attestation

I hereby attest that to the best of my knowledge and belief the information in Section II is an accurate record of the completion of a course in pharmacotherapeutics by the individual named on this form.

_____ _____
Signature Date

Print Name _____

Title or official position _____

Institution _____

Address _____

_____

Institution Seal

Telephone _____ Fax _____

Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.

Reset Form