

Date: [Date]

To:

[State Board of Nursing / Pharmacy]
[Drug Enforcement Administration (DEA)]
[Address Line 1]
[Address Line 2]

Subject: Letter of Authorization for Prescriptive Authority of Controlled Substances

To Whom It May Concern,

This letter serves as formal notification and authorization regarding the prescriptive authority for **[APN Full Name]**, [APN License Number], who is currently employed as an Advanced Practice Nurse at **[Practice/Clinic Name]**.

As the collaborating/supervising physician, I, **[Physician Full Name]**, [Physician License Number], hereby authorize [APN Full Name] to prescribe, administer, and dispense controlled substances as defined by state and federal laws.

The scope of this authorization includes:

- Schedule II Controlled Substances
- Schedule III Controlled Substances
- Schedule IV Controlled Substances
- Schedule V Controlled Substances

This authorization is granted in accordance with the Collaborative Practice Agreement on file and remains in effect until **[Expiration Date]** or until the termination of the professional relationship between the aforementioned parties.

For any further verification or inquiries, please contact me at [Physician Phone Number] or [Physician Email].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[DEA Registration Number]
[Practice Name/Address]

[APN Signature]
[APN Printed Name]
[Practice Name/Address]