

APA-1  
6/93

TRANSMITTAL SHEET FOR  
NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners

Rule No. 540-X-20, Appendix A

Rule Title: Application: Limited Purpose Schedule II Permit (LPSP)

New  Amend  Repeal  Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? YES

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? YES

Is there another, less restrictive method of regulation available that could adequately protect the public? NO

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree? NO

Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? NO

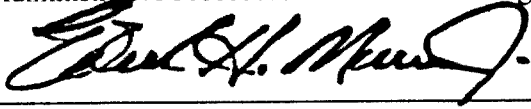
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? YES

\*\*\*\*\*  
Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

\*\*\*\*\*  
Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer 

Date: February 5, 2018

~~REC'D & FILED~~

FEB 06 2018

LEGISLATIVE SVC AGENCY

APA-2  
6/93

**ALABAMA STATE BOARD  
OF MEDICAL EXAMINERS**

**NOTICE OF INTENDED ACTION**

**AGENCY NAME:** Alabama State Board of Medical Examiners

**RULE NO. & TITLE:** 540-X-20, Appendix A, Application: Limited Purpose Schedule II Permit (LPSP)

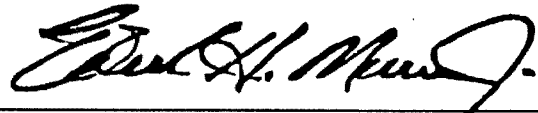
**INTENDED ACTION:** To repeal and replace the Appendix

**SUBSTANCE OF PROPOSED ACTION:** To modify the application form for online completion and elicit additional information to assist in determining the eligibility of the applicant

**TIME, PLACE, MANNER OF PRESENTING VIEWS:** All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: E. Wilson Hunter, Office of General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, 848 Washington Avenue (36104), Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including April 4, 2018. Persons wishing to obtain copies of the text of this rule should contact E. Wilson Hunter, Office of General Counsel, (334-242-4116), PO Box 946, 848 Washington Avenue (36104), Montgomery, Alabama 36101-0946. Copies of the proposed rules may also be downloaded from the Board's web site, [www.albme.org](http://www.albme.org).

**FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:** April 4, 2018

**CONTACT PERSON AT AGENCY:** Carla H. Kruger, Office of General Counsel, 334-242-4116; PO Box 946, Montgomery, AL 36101-0946; 848 Washington Avenue, Montgomery, AL 36104



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Edward H. Munson, Jr., Acting Executive Director

540-X-20, Appendix A  
Application for Limited Purpose Schedule II Permit (LPSP)

**NEW**

Application: Limited Purpose Schedule II Permit (LPSP)  
For Certified Registered Nurse Practitioners/Certified Nurse Midwives and Physician Assistants  
Fee: \$25.00

Under Alabama law, this document is a public record and will be provided upon request.

CRNP/ CNM/ PA Name

License number

Permanent address

Phone number

Email address

CP# (CRNP/ CNM only)

QACSC#

DEA# and expiration date

Certification Specialty (choose one) (CRNP/CNM only)

In what type of clinical specialty practice will this LPSP be utilized? (choose one)

This LPSP will be used with collaborating/supervising physician [name]

Medical license number

Physician specialty

If physician specialty is different from the mid-level, what is the reason? (choose one):

I practice at a remote site in a different type of clinical setting than my collaborating/supervising physician. Please provide details in the word box.

I practice at a remote site but in the same type of clinical setting as my collaborating/ supervising physician. Please provide details in word box.

I practice at the same site as my physician, and we see the same type of patients. We are both certified in different specialties, but we are practicing within our scope of practice. Please provide details in word box.

There is another reason why our specialties differ. Please provide details:

I swear (affirm) that the information set forth in this application for the Limited Purpose Schedule II Permit (LPSP) is true and correct to the best of our knowledge, information, and belief. I am familiar with the current rules regarding CRNPs/CNMs/ PAs and their ability to prescribe Schedule II controlled substances with a Qualified Alabama Controlled Substance Certificate (QACSC). I am familiar with the Board rules/protocols governing a LPSP.

Physician Signature

CRNP/CNM/PA Signature

Author: Alabama Board of Medical Examiners  
Statutory Authority: Ala. Code § 20-2-259  
History: Amended/Approved: Jan. 17, 2018.

\_Application\_

REPEAL

**LIMITED PURPOSE SCHEDULE II PERMIT (LPSP)  
FOR CERTIFIED REGISTERED NURSE PRACTITIONERS;  
CERTIFIED NURSE MIDWIVES AND PHYSICIAN ASSISTANTS**

**WARNING:** Board Rules state that an LPSP may be suspended or revoked by the Board upon a finding that an individual has furnished false or fraudulent material information in this application.

Return Completed Application To:  
**ALABAMA STATE BOARD OF MEDICAL EXAMINERS**  
Mailing Address: P.O. Box 946  
Montgomery, AL 36101  
Physical Address: 848 Washington Ave  
Montgomery, AL 36104

**Part A:**

Name in full: \_\_\_\_\_  
First Middle Last

Permanent address: \_\_\_\_\_  
Street City State Zip

Phone number: \_\_\_\_\_ Cell Number (Optional): \_\_\_\_\_

Email address: \_\_\_\_\_

**Part B:**

CHOOSE ONE (CRNP/CNM or P.A.):

\_\_\_\_\_ CRNP/CNM – I swear (affirm) I have a current, unrestricted:

A. RN License # \_\_\_\_\_ Collaborative Practice Agreement CP # \_\_\_\_\_

B. QACSC # \_\_\_\_\_ DEA # \_\_\_\_\_ Expires \_\_\_\_\_

OR

\_\_\_\_\_ P. A. — I swear (affirm) I have a current, unrestricted:

A. PA License # \_\_\_\_\_ Registration Agreement RA # \_\_\_\_\_

B. QACSC # \_\_\_\_\_ DEA # \_\_\_\_\_ Expires \_\_\_\_\_

**Part C:**

This LPSP will be used with Collaborating/Supervising Physician: \_\_\_\_\_

Collaborating/Supervising Physician's Medical Specialty: \_\_\_\_\_

**Part D:**

We swear (affirm) that the information set forth in this application for the Limited Purpose Schedule II Permit is true and correct to the best of our knowledge, information and belief.

\_\_\_\_\_  
Physician Signature Date

\_\_\_\_\_  
Mid-Level Practitioner Signature and Title Date

**\*\*THE FEE FOR THIS APPLICATION IS \$25.00\*\***