

Florida Board of Nursing  
PO Box 6330  
Tallahassee, FL 32314  
Phone: (850) 245-4125  
Fax: (850) 617-6460

## Dispensing Application for Advanced Practice Registered Nurse (APRN)

Please complete this application in  
its entirety prior to printing.

Do Not Write in this Space  
For Revenue Receipting Only

**Dispensing** is defined as selling medicinal drugs to patients in the office. A practitioner who writes prescriptions or provides complimentary samples is not a "dispensing practitioner," and therefore does not need to register with the department.

The fee of \$100.00 must be paid in the form of a cashier's check or money order, made payable to: DOH Florida Board of Nursing

1.

<b>Name:</b>			
_____	_____	_____	_____
Last/Surname	First	Middle	Florida License #
<b>Mailing Address: (Give the address where mail and your license should be sent)</b>			
_____		_____	_____
Street/ P.O. Box		Apt. No.	City
_____		_____	
State	Zip	Country	Home/Cell Telephone (Input with dashes)
<b>Physical Location: This address should be where you will be/are dispensing. If dispensing at more than one location please attach an additional sheet with other locations.</b>			
_____		_____	_____
Street		Apt. No.	City
_____		_____	
State	Zip	Country	Work/Cell Telephone (Input with dashes)

Yes  No Do you have any additional pages attached?

I certify that the information on this form is true and correct. I dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted.

**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
This field cannot be typed. You must print out the application and sign it. MM/DD/YYYY