

**NYS DEPARTMENT OF HEALTH**  
**Mandatory Prescriber Education - ATTESTATION**

Every practitioner licensed under Title Eight of the Education Law in New York to treat humans and registered with the Drug Enforcement Administration (DEA) to prescribe controlled substances must complete three hours of accredited course work or training on pain management, palliative care and addiction.

The following specific topics must be included in the training:

- State and federal requirements for prescribing controlled substances
- Pain management
- Appropriate prescribing
- Managing acute pain
- Palliative medicine
- Prevention, screening, and signs of addiction
- Responses to abuse and addiction
- End of life care

<b>I. PRESCRIBER INFORMATION - Please Print Legibly &amp; List License Number(s) with Profession</b>	
<b>Prescriber Name:</b> _____ <b>E-mail:</b> _____ <b>Contact Phone #</b> ( ____ ) ____ - ____	
<b>Mailing Address:</b> _____ <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>Street</span> <span>City</span> <span>State</span> <span>Zip</span> </div>	
License #: _____  <b>Profession (Please select one):</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Dentist  <input type="checkbox"/> Midwife  <input type="checkbox"/> Nurse Practitioner, Adult Health  <input type="checkbox"/> Nurse Practitioner, College Health  <input type="checkbox"/> Nurse Practitioner, Family Health  <input type="checkbox"/> Nurse Practitioner, Holistic medicine  <input type="checkbox"/> Nurse Practitioner, Obstetrics &amp; Gynecology  <input type="checkbox"/> Nurse Practitioner, Palliative Care  <input type="checkbox"/> Nurse Practitioner, Perinatology  <input type="checkbox"/> Nurse Practitioner, School Health  <input type="checkbox"/> Podiatrist             </div> <div style="width: 50%;"> <input type="checkbox"/> Medicine  <input type="checkbox"/> Nurse Practitioner, Acute Care  <input type="checkbox"/> Nurse Practitioner, Anesthesia  <input type="checkbox"/> Nurse Practitioner, Community Health  <input type="checkbox"/> Nurse Practitioner, Gerontology  <input type="checkbox"/> Nurse Practitioner, Neonatology  <input type="checkbox"/> Nurse Practitioner, Oncology  <input type="checkbox"/> Nurse Practitioner, Pediatrics  <input type="checkbox"/> Nurse Practitioner, Psychiatry  <input type="checkbox"/> Nurse Practitioner, Women's Health  <input type="checkbox"/> Registered Physician Assistant             </div> </div>	License #: _____  <b>Profession (Please select one):</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Dentist  <input type="checkbox"/> Midwife  <input type="checkbox"/> Nurse Practitioner, Adult Health  <input type="checkbox"/> Nurse Practitioner, College Health  <input type="checkbox"/> Nurse Practitioner, Family Health  <input type="checkbox"/> Nurse Practitioner, Holistic medicine  <input type="checkbox"/> Nurse Practitioner, Obstetrics &amp; Gynecology  <input type="checkbox"/> Nurse Practitioner, Palliative Care  <input type="checkbox"/> Nurse Practitioner, Perinatology  <input type="checkbox"/> Nurse Practitioner, School Health  <input type="checkbox"/> Podiatrist             </div> <div style="width: 50%;"> <input type="checkbox"/> Medicine  <input type="checkbox"/> Nurse Practitioner, Acute Care  <input type="checkbox"/> Nurse Practitioner, Anesthesia  <input type="checkbox"/> Nurse Practitioner, Community Health  <input type="checkbox"/> Nurse Practitioner, Gerontology  <input type="checkbox"/> Nurse Practitioner, Neonatology  <input type="checkbox"/> Nurse Practitioner, Oncology  <input type="checkbox"/> Nurse Practitioner, Pediatrics  <input type="checkbox"/> Nurse Practitioner, Psychiatry  <input type="checkbox"/> Nurse Practitioner, Women's Health  <input type="checkbox"/> Registered Physician Assistant             </div> </div>

**II. PRESCRIBER ATTESTATION OF COMPLETION**

**With my signature below, I attest that:**

- 1. I have completed a minimum of three hours of required accredited course work or training on pain management, palliative care and addiction, which included each of the eight topics specified above.**
- 2. Records of such training shall be available for audit and inspection by the Department of Health, and shall be retained for six years from the date of submission of this attestation.**

Practitioner's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name \_\_\_\_\_

**False statements made herein are punishable as a class A misdemeanor pursuant to §210.45 of the Penal Law.**

**III. SUBMIT ATTESTATION**

**Please scan & email completed form to [narcotic@health.ny.gov](mailto:narcotic@health.ny.gov) with subject line: "Mandatory Prescriber Education - Attestation".**

*OR fax to 518-402-1058 or,*

**Mail hardcopy form to:**

New York State Department of Health  
Bureau of Narcotic Enforcement  
Riverview Center  
150 Broadway  
Albany, NY 12204

**Any questions please call (866) 811 – 7957**