NOVA SCOTIA Regulator of Dietetics

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# AUTHORIZED PRESCRIBER APPLICATION

## EMPLOYER APPROVAL FORM

| DIETITIAN NAME | REGISTRATION NUMBER |
|---|---|
| YOUR NAME (PRINT) | TITLE |
| ORGANIZATION/SITE | |
| EMPLOYER EMAIL | EMPLOYER PHONE |

## PRESCRIBING PRACTICE SETTING

| | |
|---|---|
| I ACKNOWLEDGE THAT THE DIETITIAN NAMED ABOVE IS AUTHORIZED TO PRESCRIBE BY THE ORGANZIATION NAMED ABOVE. | YES ☐ NO ☐ |
| RESOURCES REFLECTING THE PRESCRIBING STANDARDS OF PRACTICE AND COMPETENCIES, INCLUDING BUT NOT LIMITED TO DECISION SUPPORT TOOLS, POLICIES, GUIDELINES, REFERENCES, MENTORS, ETC. ARE IN PLACE TO SUPPORT SAFE AND COMPETENT PRACTICE OF DIETITIAN PRESCRIBING. | YES ☐ NO ☐ |
| THERE IS AN ESTABLISHED PROCESS TO ENABLE COLLABORATION BETWEEN THE DIETITIAN PRESCRIBER AND AN APPROPRIATE HEALTH CARE PROVIDER, SUCH AS NURSE PRACTITIONER, PHARMACIST, OR PHYSICIAN. | YES ☐ NO ☐ |
| I ACKNOWLEDGE THAT THE DIETITIAN PRESCRIBER'S AUTHORITY TO PRESCRIBE IS SPECIFIC AND LIMITED TO THE CLIENT CONDITIONS AND PRACTICE SETTINGS AS IDENTIFIED BY THE EMPLOYER RESOURCES, POLICIES, GUIDELINES, AND/OR OTHER DECISION SUPPORT TOOLS. | YES ☐ NO ☐ |
| I CONSENT FOR THE NSRD TO CONTACT ME AT THE INFORMATION ABOVE, AND ACKNOWLEDGE THAT THE DIETITIANS APPLICATION TO PRESCRIBE WILL NOT BE PROCESSED UNTIL I HAVE BEEN CONTACTED TO VALIDATE THEIR EMPLOYMENT. | YES ☐ NO ☐ |

| EMPLOYER OR SUPERVISOR SIGNATURE | DATE |
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