



Nurse Practitioner's Statement of Authorization

By my signature below, I certify that I am a nurse practitioner licensed by:

☐ Oregon State Board of Nursing. License no.: _____

☐ Other _____ License no.: _____

I have reviewed and understand the *Nurse Practitioner's Handbook* along with the enclosed informational packet. I agree to treat patients with Oregon on-the-job injuries in accordance with Oregon law.

Signature: _____ Date: _____

(Please print)

Name: _____

Primary
business
address: _____

Phone no.: _____

Fax no.: _____

Business
email: _____

FEIN (Federal employer tax identification number) (if available): _____

NPI (National provider identifier) (if available): _____

Please return this form to: Workers' Compensation Division
Policy Team
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
Fax: 503-947-7514

Once we receive this completed form, we will send you an authorized nurse practitioner (ANP) number.