FORM TO TERMINATE A COLLABORATIVE PRACTICE AGREEMENT

To terminate your collaborative practice agreement, complete this form and submit through your Nurse Portal.

I, _____ _____, am notifying the Arkansas
(First & Last Name & Title) *(License #)*

State Board of Nursing that I am **terminating** my Collaborative Practice Agreement & Quality Assurance Plan with the following physician(s) to be effective on _____.

_____, MD _____, MD

_____, MD _____, MD

_____, MD _____, MD

Name of Practice Site: _____

☐ I am **not** submitting a new Collaborative Practice Agreement at this time. I acknowledge that my prescriptive authority will be inactive until I apply to reinstate and submit a new Collaborative Practice Agreement and Quality Assurance Plan.

OR

☐ I hold a current Certificate of Full Independent Practice.

OR

☐ I am submitting a **new** Collaborative Practice Agreement, which includes my collaborating physician/s and Quality Assurance Plan, to be effective on _____.

AND/OR

☐ I have a current ASBN approved Collaborative Practice Agreement with Dr. _____ at _____ therefore my prescriptive authority will remain active.
Practice Name

I understand that I **cannot** receive or prescribe medications or therapeutic devices unless I have an approved Collaborative Practice Agreement and Quality Assurance Plan on file with ASBN or hold a Certificate of Full Independent Practice.

_____ _____
(Signature of APRN) *(Date Signed)*

This form is to be submitted through the Arkansas Nurse Portal Message Center. Revised: 9/1/2026