

Collaborative Practice Agreement

This agreement is for the management of the collaborative practice between:

_____, APRN, and _____, MD/DO.

The physician hereby agrees to be available to the Advanced Practice Registered Nurse (APRN), either in person or via electronic or telephonic communication, for consultation and referral. Mutually agreed upon protocols for Prescriptive Authority will be utilized by the APRN as a guide for general categories of health states. The APRN shall limit prescribing to the area of educational preparation and certification as noted below.

The above named APRN is authorized to prescribe drugs from each of the categories of controlled substances below which are initialed by the collaborating physician and APRN.

- _____ **a. Drugs listed in Schedule III-V of the Controlled Substance Act (CSA), 17-87-310 (b)(2)(A)**
- _____ **b. Hydrocodone combination products from Schedule II of the CSA, 17-87-310 (b)(2)(A)**
- _____ **c. Schedule II opioids and /or stimulants, 17-87-310 (b)(2)(B)**
- _____ **d. Not requesting ability to prescribe controlled substances**

Should an emergency arise, necessitating the absence of the APRN or the collaborating physician from patient care responsibilities, provision for comparable coverage shall be arranged at the first possible opportunity.

Until that time, _____ with which the collaborating providers are associated, provides emergency services 24-hours daily for the clients of _____.

There is a written provision for quality assurance (attach the Quality Assurance Plan).

This agreement of professional collaboration is by no means intended as a business contract but rather as a document that fulfills the requirements for Prescriptive Authority as set forth in the Arkansas *Nurse Practice Act*. The signatures below signify agreement to the terms of the collaborative practice.

_____, APRN

_____, MD/DO

Print Name _____

Print Name _____

APRN AR License # _____

MD/DO AR License # _____

Certification/Specialty _____

Certification/Specialty _____

Additional Certification _____

Practice Site Same as APRN

Practice Site _____

Practice Address (Street, City, County, Zip):

Practice Address (Street, City, County, Zip):

Date Signed _____

Date Signed _____

Practice Phone # _____

Collaborative Practice Agreement with Multiple Physicians

The signatures below signify mutual agreement to the terms of the Collaborative Practice Agreement.

_____, MD/DO MD/DO AR License # _____
Print name _____ Area of certification _____
Practice Site _____ Practice Address _____
(Street)
 Practice site same as APRN _____
(City) (County) (Zip)
Date Signed _____

_____, MD/DO MD/DO AR License # _____
Print name _____ Area of certification _____
Practice Site _____ Practice Address _____
(Street)
 Practice site same as APRN _____
(City) (County) (Zip)
Date Signed _____

_____, MD/DO MD/DO AR License # _____
Print name _____ Area of certification _____
Practice Site _____ Practice Address _____
(Street)
 Practice site same as APRN _____
(City) (County) (Zip)
Date Signed _____

_____, MD/DO MD/DO AR License # _____
Print name _____ Area of certification _____
Practice Site _____ Practice Address _____
(Street)
 Practice site same as APRN _____
(City) (County) (Zip)
Date Signed _____

****Additional copies of this sheet can be copied and included***