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 national 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)**

_____ _____**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, in the absence of the APRN or the collaborating physician, comparable coverage shall be arranged at the first possible opportunity by the APRN.

Until that time, clients will be referred to _____ for 24-hour emergency services for the clients of _____.

There is a written provision for quality assurance (attach the Quality Assurance Plan). Compliance with the quality assurance plan shall be submitted to the Board upon request.

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* §17-87-310 (a)(2)(B). The signatures below signify agreement to the terms of the collaborative practice.

_____, APRN

Print Name_____

APRN AR License #_____

Certification/Specialty Select

Additional Certification N/A

Practice Name _____

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

_____

_____

Date Signed_____

Practice Phone #_____

_____, MD/DO

Print Name_____

MD/DO AR License # _____

Primary Specialty_____

☐ Practice Name Same as APRN

Practice Name _____

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

_____

_____

Date Signed_____

Collaborative Practice Agreement with Multiple Physicians

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

_____, MD/DO

Print name_____

Practice Name_____

☐ Practice name same as APRN

Date Signed_____

MD/DO AR License #_____

Primary Specialty _____

Practice Address_____
(Street)

_____
(City) (State) (Zip)

_____, MD/DO

Print name_____

Practice Name_____

☐ Practice name same as APRN

Date Signed_____

MD/DO AR License #_____

Primary Specialty _____

Practice Address_____
(Street)

_____
(City) (State) (Zip)

_____, MD/DO

Print name_____

Practice Name_____

☐ Practice name same as APRN

Date Signed_____

MD/DO AR License #_____

Primary Specialty _____

Practice Address_____
(Street)

_____
(City) (State) (Zip)

_____, MD/DO

Print name_____

Practice Name_____

☐ Practice name same as APRN

Date Signed_____

MD/DO AR License #_____

Primary Specialty _____

Practice Address_____
(Street)

_____
(City) (State) (Zip)

Additional copies of this sheet can be copied and included