

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
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Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

ADDITIONAL PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT

1. This application is only used for entering into an **additional** prescriptive authority collaborative agreement. If this is the **first** prescriptive authority collaborative agreement, you must complete the **Initial Application for Nurse-Midwife Prescriptive Authority**. If you are making any changes to an existing collaborative agreement, complete and submit the **Collaborative Agreement Change Form**.
2. This application may be used to request an additional prescriptive authority collaborative agreement with an allopathic or osteopathic physician licensed by the State Boards of Medicine or Osteopathic Medicine. The physician must have hospital privileges (or a formal arrangement for patient admission to a hospital) and shall practice in the specialty area of the care for which the physician is providing collaborative services.
3. **A copy of the prescriptive authority collaborative agreement must be submitted with this application.**
4. Pennsylvania law requires you to maintain a copy of this application as well as your prescriptive authority collaborative agreement.
5. **Application Fee: \$30 – NOT REFUNDABLE.** Make check payable to the “Commonwealth of Pennsylvania.” **Note:** A processing fee of \$20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

PLEASE NOTE: If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.

YOU MAY NOT PRACTICE/PREScribe UNDER THIS PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT UNTIL YOU HAVE COMPLETED THE APPLICATION AND A REGISTRATION LETTER HAS BEEN ISSUED BY THE BOARD.

APPLICANT INFORMATION (Please Print or Type)

NAME OF NURSE-MIDWIFE:	Last	First	Middle
NURSE-MIDWIFE LICENSE NO.			
TELEPHONE NUMBER:			
EMAIL ADDRESS:			
NAME OF COLLABORATING PHYSICIAN:	Last	First	Middle
PHYSICIAN LICENSE NO.			

CHECK ALL OF THE CONTROLLED SUBSTANCE SCHEDULES THAT THE NURSE-MIDWIFE WILL PRESCRIBE and/or DISPENSE

Schedule II

Schedule III

Schedule IV

Schedule V

LIST BELOW THE CATEGORIES OF DRUGS FROM WHICH THE NURSE-MIDWIFE MAY PRESCRIBE/DISPENSE AND ANY RESTRICTIONS THERETO. (IF YOU REQUIRE ADDITIONAL SPACE, PLEASE USE A SEPARATE SHEET OF 8 1/2" X 11" PAPER.)

Categories CNM May Prescribe/Dispense

Restrictions

STATEMENTS AND SIGNATURES

Nurse-Midwife: This agreement contains the details of the prescriptive authority collaborative arrangement between myself and the below-signed collaborating physician with respect to the care of midwifery patients and the prescribing and dispensing of drugs.

NURSE-MIDWIFE SIGNATURE:

Date

Collaborating Physician: This agreement contains the details of the prescriptive authority collaborative arrangement between myself and the above-signed nurse-midwife with respect to the care of midwifery patients and the prescribing and dispensing of drugs. I attest that I have knowledge and experience with any drug that the nurse-midwife will prescribe and dispense.

COLLABORATING PHYSICIAN SIGNATURE:

Date