Regular Mailing Address	Courier Delivery Address
STATE BOARD OF MEDICINE **P.O. BOX 2649** **HARRISBURG, PA 17105-2649** **717-783-1400/717-787-2381** **Email:** st-medicine@pa.gov	**STATE BOARD OF MEDICINE** **2601 NORTH THIRD STREET** **HARRISBURG, PA 17110**

ADDITIONAL COLLABORATIVE AGREEMENT FOR NURSE-MIDWIFE LICENSE

1.	This application is only used for entering into an **additional** collaborative agreement. If this is the **first** collaborative agreement, complete the application titled, **Initial Collaborative Agreement for Nurse-Midwife License.** If making changes to or terminating an existing collaborative agreement, complete and submit the **Collaborative Agreement Change Form**.
2.	This application may be used to request an additional 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. **This collaborative agreement will NOT include prescriptive authority privileges**.
3.	**A copy of the collaborative agreement must be submitted with this application.**
4.	Pennsylvania law requires you to maintain a copy of this application as well as your 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 UNDER THIS COLLABORATIVE AGREEMENT UNTIL THE REGISTRATION IS COMPLETE AND FILED WITH THE BOARD.

APPLICANT INFORMATION

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

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

NURSE-MIDWIFE SIGNATURE:		Date

Collaborating Physician: This agreement contains the details of the collaborative arrangement between myself and the above-signed nurse-midwife with respect to the care of midwifery patients.

COLLABORATING PHYSICIAN SIGNATURE:		Date