

Regular Mailing Address
 STATE BOARD OF MEDICINE
 P.O. BOX 2649
 HARRISBURG, PA 17105-2649
 717-783-1400/717-787-2381
 Email: st-medicine@pa.gov

Courier Delivery Address
 STATE BOARD OF MEDICINE
 2601 NORTH THIRD STREET
 HARRISBURG, PA 17110

NURSE-MIDWIFE COLLABORATIVE AGREEMENT CHANGE FORM

The nurse-midwife shall notify the Board, in writing, of a change in or termination of a collaborative agreement, change in mailing address, address of employment, and any change of collaborating physician. A change in medical staff of a medical practice identified in the collaborative agreement is not a change in the collaborative agreement, so long as the named collaborating physician continues to serve as the collaborating physician with the nurse-midwife under the collaborative agreement.

Failure of a nurse-midwife to notify the Board within 30 days of changes in or a termination of the collaborative physician/nurse-midwife relationship is a basis for disciplinary action against the nurse-midwife's license. If your collaborative agreement with this physician does NOT provide information regarding another physician in the same group or practice who has agreed to provide interim coverage for up to 30 days (as per Section 18.9 of the regulations), you cannot fulfill the requirements to practice.

*This form must be completed when reporting a change to an existing collaborative agreement. Please duplicate, as needed.

*Original signatures are required. Upon filing of the requested changes, a confirmation letter will be sent to the nurse-midwife. The letter will be mailed to the contact information on file with the Board. If the address has changed, an address change form will need to be completed.

INSTRUCTIONS – NURSE-MIDWIFE COLLABORATIVE AGREEMENT

1. **DELETING A COLLABORATIVE AGREEMENT:** Complete Section A. The signature of the nurse-midwife or the collaborating physician is required. **Please Note: The nurse-midwife may not practice without having a collaborative agreement registered with the Board.**
2. **CHANGES TO THE COLLABORATIVE AGREEMENT:** Complete Section B. **Submit a copy of the updated, signed collaborative agreement with this form.**
3. **CHANGE OF COLLABORATING PHYSICIAN ONLY:**
 - In order to use this form, the new collaborating physician must be in the same group or practice as the collaborating physician to be replaced. If the new collaborating physician is not in the same group or practice, submit the form titled, "Additional Collaborative Agreement for Nurse-Midwife License."
 - Complete Section C. **Submit a copy of the updated, signed collaborative agreement with this form.**

**INSTRUCTIONS – NURSE-MIDWIFE
PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT**

1.	<p>DELETING A NURSE-MIDWIFE PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT: Complete Section A. The signature of the nurse-midwife or the collaborating physician is required. Please note: The nurse-midwife may not practice without having a collaborative agreement registered with the Board. The nurse-midwife prescriptive authority certificate will be placed on inactive status if there are no other collaborative agreements with prescriptive authority.</p>
2.	<p>CHANGES TO THE PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT: Complete Sections D, E, and F. Submit <u>a copy of the updated, signed collaborative agreement with this form.</u></p>
3.	<p>CHANGE OF PRESCRIPTIVE AUTHORITY COLLABORATING PHYSICIAN ONLY:</p> <ul style="list-style-type: none"> • In order to use this form, the new collaborating physician must be in the same group or practice as the collaborating physician to be replaced. If the new collaborating physician is not in the same group or practice, submit the form titled, "Additional Prescriptive Authority Collaborative Agreement." • Complete Section C and F. <u>Submit a copy of the updated, signed collaborative agreement with this form.</u>

EFFECTIVE JAN. 1, 2017, ACT 191 OF 2014 REQUIRES ALL PRESCRIBERS AND DISPENSERS TO REGISTER FOR THE PENNSYLVANIA PRESCRIPTION DRUG MONITORING PROGRAM (PA PDMP). PRESCRIBERS ARE REQUIRED TO QUERY THE PA PDMP SYSTEM FOR EACH PATIENT THE FIRST TIME THE PATIENT IS PRESCRIBED A CONTROLLED SUBSTANCE BY THE PRESCRIBER, WHEN THERE IS CLINICAL CONCERN THAT THE PATIENT MAY BE ABUSING OR DIVERTING A CONTROLLED SUBSTANCE(S), AND/OR EACH TIME THE PATIENT IS PRESCRIBED AN OPIOID DRUG PRODUCT OR A BENZODIAZEPINE. TO LEARN MORE AND TO REGISTER, PLEASE VISIT WWW.DOH.PA.GOV/PDMP.

Regular Mailing Address
 STATE BOARD OF MEDICINE
 P.O. BOX 2649
 HARRISBURG, PA 17105-2649
 717-783-1400/717-787-2381
 Email: st-medicine@pa.gov

Courier Delivery Address
 STATE BOARD OF MEDICINE
 2601 NORTH THIRD STREET
 HARRISBURG, PA 17110

NURSE-MIDWIFE COLLABORATIVE AGREEMENT CHANGE FORM

SECTION A - DELETING A COLLABORATIVE AGREEMENT

NAME OF NURSE-MIDWIFE:	Last	First	Middle
NURSE-MIDWIFE LICENSE NO.:			
SIGNATURE OF NURSE-MIDWIFE:			Date
NAME OF COLLABORATING PHYSICIAN:	Last	First	Middle
PHYSICIAN LICENSE NO.:			
SIGNATURE OF PHYSICIAN:			Date

SECTION B – CHANGES TO A NURSE-MIDWIFE COLLABORATIVE AGREEMENT

NAME OF NURSE-MIDWIFE:	Last	First	Middle
NURSE-MIDWIFE LICENSE NO.:			
This agreement contains the details of the collaborative arrangement between myself and the below-named collaborating physician with respect to the care of midwifery patients.			
SIGNATURE OF NURSE-MIDWIFE:			Date
TELEPHONE NO:			
EMAIL ADDRESS:			
NAME OF COLLABORATING PHYSICIAN:	Last	First	Middle
PHYSICIAN LICENSE NO.:			
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.			
SIGNATURE OF PHYSICIAN:			Date

Regular Mailing Address
 STATE BOARD OF MEDICINE
 P.O. BOX 2649
 HARRISBURG, PA 17105-2649
 717-783-1400/717-787-2381
 Email: st-medicine@pa.gov

Courier Delivery Address
 STATE BOARD OF MEDICINE
 2601 NORTH THIRD STREET
 HARRISBURG, PA 17110

NURSE-MIDWIFE COLLABORATIVE AGREEMENT CHANGE FORM

SECTION C – CHANGE OF COLLABORATING PHYSICIAN ONLY

In order to use this form, the new collaborating physician must be in the same group or practice as the collaborating physician to be replaced. If the new collaborating physician is **not** in the same group or practice, you **cannot** use this form.

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

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.

SIGNATURE OF NURSE-MIDWIFE:		Date	
NAME OF NEW COLLABORATING PHYSICIAN:	Last	First	Middle
PHYSICIAN LICENSE NO.:			

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.

SIGNATURE OF COLLABORATING PHYSICIAN:		Date
--	--	-------------

Regular Mailing Address
 STATE BOARD OF MEDICINE
 P.O. BOX 2649
 HARRISBURG, PA 17105-2649
 717-783-1400/717-787-2381
 Email: st-medicine@pa.gov

Courier Delivery Address
 STATE BOARD OF MEDICINE
 2601 NORTH THIRD STREET
 HARRISBURG, PA 17110

NURSE-MIDWIFE COLLABORATIVE AGREEMENT CHANGE FORM

PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT

SECTION D – CHANGE IN CONTROLLED SUBSTANCE SCHEDULES

Will there be a change in the controlled substance schedules that the Nurse-Midwife with Prescriptive Authority will prescribe/dispense?

 Yes
 No

If Yes, check all the controlled substance schedules that the Nurse-Midwife with Prescriptive Authority will prescribe/dispense:

 Schedule II
 Schedule III
 Schedule IV
 Schedule V

SECTION E – CHANGE IN DRUG CATEGORIES

Will there be a change in the drug categories that the Nurse-Midwife with Prescriptive Authority will be prescribing and/or dispensing?

 Yes
 No

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 ½" x 11" paper.)

Categories CNM May Prescribe/Dispense

Restrictions

SECTION F – VERIFICATION

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.

NAME OF NURSE-MIDWIFE WITH PRESCRIPTIVE AUTHORITY:	Last	First	Middle
NURSE-MIDWIFE SIGNATURE:			Date
TELEPHONE NO:			
EMAIL ADDRESS:			

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.

NAME OF COLLABORATING PHYSICIAN:	Last	First	Middle
COLLABORATING PHYSICIAN SIGNATURE:			Date