PENNSYLVANIA STATE BOARD OF NURSING
P.O. BOX 2649
HARRISBURG, PA 17105-2649

PHONE (717) 783-7142
FAX (717) 783-0822
www.dos.state.pa.us/nurse
Email: st-nurse@pa.gov

CHANGE OF PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT

*********DO NOT use this form if you are CHANGING your Collaborating Physician*********

You MUST submit a new *CRNP Application for Prescriptive Authority.* The application is available at www.dos.state.pa.us/nurse under "Board Forms/Applications."

General Instructions

1. Verify ALL names/licenses at www.licensepa.state.pa.us before submitting.
2. Include ALL **zeros** and **prefixes/suffixes** for each license/certificate number.
3. Collaborating Physician listed on the Change Form must match the Collaborating Physician you listed on your Prescriptive Authority Application.
4. If there are changes to your Prescriptive Authority Collaborative Agreement that are not addressed on the form, such as additional practice locations, please contact the State Board of Nursing for further instruction.
5. No fee is required for submission of any Change Form.
6. A letter confirming the change will be forwarded from the State Board of Nursing once processed.

IMPORTANT: The CRNP must keep a copy of any Change of Prescriptive Authority Collaborative Agreement Form submitted to the State Board of Nursing.

To verify an agreement is **TERMINATED,** refer to the website www.licensepa.state.pa.us.

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Change of Prescriptive Authority Collaborative Agreement: Circumstances and How Often the Collaborating Physician Will Personally See the Patient

_____
PRESCRIPTIVE AUTHORITY NUMBER

_____
NAME OF CRNP

_____
NAME OF COLLABORATING PHYSICIAN

_____
PENNSYLVANIA CRNP CERTIFICATE NUMBER

_____
PHYSICIAN LICENSE NUMBER
(Include all prefixes/suffixes)

_____
PHONE NUMBER/EMAIL

Indicate the circumstances and how often the Collaborating Physician will personally see the patient.

☐ Once per year ☐ Twice per year ☐ Daily ☐ Every other visit

☐ CRNP Request ☐ Patient or Family request ☐ Patient not responding to treatment

☐ Patient condition outside CRNP scope of practice ☐ Other _____

_____
Signature of CRNP **Date Signed**

AND

_____
Signature of Collaborating Physician **Date Signed**

THE CHANGE IS NOT EFFECTIVE UNTIL YOU HAVE RECEIVED A LETTER FROM THE STATE BOARD OF NURSING