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

Submit this form to TERMINATE a Prescriptive Authority Collaborative Agreement if you no longer collaborate with that Collaborating Physician.

To have a new Collaborating Physician for prescriptive authority, you MUST submit a new *CRNP Application for Prescriptive Authority.* The application is available at www.dos.state.pa.us/nurse, click on "Board Forms/Applications." Once approved, you will then receive a new Prescriptive Authority Approval Number associated with the new Collaborating Physician.

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 form must be the physician associated with the Prescriptive Authority number entered on the change form.
4. If there are changes to your prescriptive authority collaborative agreement that are not addressed on this form, such as additional practice locations, please contact the Board of Nursing for further instruction.
5. No fee is required for submission of any of the change forms.
6. To verify an agreement has been **TERMINATED,** refer to the website www.licensepa.state.pa.us.

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

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Change of Prescriptive Authority Collaborative Agreement: Termination

_____
PRESCRIPTIVE AUTHORITY NUMBER

NAME OF CRNP	**NAME OF COLLABORATING PHYSICIAN**
PENNSYLVANIA CRNP CERTIFICATE NUMBER	**PHYSICIAN LICENSE NUMBER (Include all prefixes/suffixes)**
PHONE NUMBER/E-MAIL (if CRNP is terminating)	**PHONE NUMBER/E-MAIL (if physician is terminating)**

_____
EFFECTIVE DATE OF TERMINATION (required)

Termination of agreement - The Agreement between the CRNP and the Collaborating Physician above is terminated. The CRNP may ***not*** continue to prescribe and dispense drugs under the authority of this physician.

_____
Signature of CRNP **Date Signed**

OR

_____
Signature of Collaborating Physician **Date Signed**