[*LETTERHEAD*]

Collaborative Practice Agreement for Advanced Practice Nurses Requesting Prescriptive Authority

Rule 848 IAC 5-1-1 – Initial Authority to Prescribe Legend Drugs

1. Complete names, home and business addresses, zip codes, and telephone numbers of the licensed practitioner and the advanced practice nurse:

Licensed Practitioner:	*Advanced Practice Nurse:*
Licensed Practitioner's name Indiana license number	Licensed Practitioner's name Indiana license number
Street address of home City, State & Zip of home Home phone number	Street address of home City, State & Zip of home Home phone number
Business street address City, State & Zip of business Business phone number	Business street address City, State & Zip of business Business phone number

2. List of all locations where prescriptive authority is authorized by this agreement.

Business street address
City, State & Zip of business
Business phone number

3. List all specialty or board certifications of the licensed practitioner and the advanced practice nurse.

Licensed practitioner is certified as a ________________ with a practice specialty in ___________. The advanced practice nurse is a nurse practitioner, clinical nurse specialist, certified nurse midwife, etc., with a specialized certification as a family nurse practitioner, etc.

4. Briefly describe the specific manner of collaboration between the licensed practitioner and advance practice nurse. *Specifically, how they will work together, how they will share practice trends and responsibilities, how they maintain geographic proximity and how they will provide coverage during an absence, incapacity, infirmity or emergency by the licensed practitioner.*

The licensed practitioner and advanced practice nurse shall collaborate on a continual basis, etc.
The advanced practice nurse shall make rounds at the request of the licensed practitioner and consult with the license practitioner as needed, etc.
The licensed practitioner will maintain a physical presence within a reasonable geographic proximity to the advanced practice nurse's practice location.

SAMPLE

In the case of the absence, incapacity, or unavailability of the licensed practitioner, coverage and consultation will be coordinated and maintained by another licensed practitioner as arranged in advance by the licensed practitioner and the advanced practice nurse.

5. Provide a description of limitations, if any, the licensed practitioner has placed on the advanced practice nurse's prescriptive authority.

There are no additional limitations on the advanced practice nurse or there are the following limitations on the advanced practice nurse, etc.

6. Provide a description of the time and manner of the licensed practitioner's review of the advanced practice nurse's prescribing practices. *Specifically, the description should include provisions that the advanced practice nurse must submit documentation of prescribing practices to the licensed practitioner within seven (7) days. Documentation of prescribing practices shall include, but not be limited to, at least a five (5) percent random sampling of the charts and medications prescribed for patients.*

The advanced practice nurse must submit documentation of the advance practice nurse's prescribing practices within seven days to the licensed practitioner for review. The documentation of prescribing practices shall include at least a five percent random sampling of the charts and medications prescribed for patients.

7. Provide a list of all other written practice agreements of the licensed practitioner and advanced practice nurse.

There are no other practice agreements or list all other practice agreements, etc.

8. Provide the duration of the written practice agreement between the licensed practitioner and advanced practice nurse.

The agreement commences on ______________ or as the signing date below.
Either party may terminate this practice agreement without cause at any time, effective immediately upon notice to the other party, etc.

Signature of Licensed Practitioner:	***Signature of Advanced Practice Nurse:***
______________________________	________________________________
Date: ________________________	**Date:** _________________________

SAMPLE