



TYPE YOUR NAME  
(AS IT APPEARS ON YOUR LICENSE)

THIS ENTIRE DOCUMENT MUST BE TYPED

NURSE PRACTITIONER WRITTEN COLLABORATIVE AGREEMENT

Please review the online instructions before completing this document.

You Must Attach This Page To Your Agreement or Addendum

NEW AGREEMENT

SUBMIT PAGES 1 THROUGH 14 (WITH ORIGINAL SIGNATURES ON PAGE 14)

(A resume, copies of CDS and DEA licenses, and copies of current CPR, ACLS, PALS and/or NRP certifications must be submitted with each "New" Agreement.)

ADDENDUM

(REVISED/AMENDED AGREEMENT)

Resumes are not required with Addendums

(CHECK ANY OF THE FOLLOWING THAT APPLY)

ADDITION OF A PHYSICIAN OR CHANGE IN PHYSICIAN COLLABORATORS (SAME PRACTICE OR ORGANIZATION). If adding physicians, do not include physicians who are currently active on the agreement.

DO NOT SUBMIT THE ENTIRE AGREEMENT.

- SUBMIT PAGES 1, 2, 3, 6 AND 14 (WITH ORIGINAL SIGNATURES ON PAGE 14).

CHANGE IN PRACTICE SITE [SAME PHYSICIANS, SAME ORGANIZATION, SAME JOB DESCRIPTION]

DO NOT SUBMIT THE ENTIRE AGREEMENT.

- SUBMIT PAGES 1, 2, 3, 6 AND 14 (WITH ORIGINAL SIGNATURES ON PAGE 14).

COMPETENCY FORMS FOR NEW PROCEDURES: THE COLLABORATING PHYSICIAN (S) OR THE ORIGINAL EVALUATOR MUST SIGN COMPETENCY FORMS FOR NEW PROCEDURES

DO NOT SUBMIT THE ENTIRE AGREEMENT.

- SUBMIT PAGES 1, 2, 3, 6, 14 AND 15 (WITH ORIGINAL SIGNATURES ON PAGE 14).
- IF COMPETENCIES WERE OBTAINED IN ANOTHER SETTING, THE SIGNATURES OF THE PHYSICIAN OR THE EVALUATOR ARE REQUIRED.

ADDING PRESCRIPTIVE AUTHORITY AND/OR CONTROLLED DANGEROUS SUBSTANCES (CDS)

DO NOT SUBMIT THE ENTIRE AGREEMENT.

- SUBMIT PAGES 1, 2, 3, 6, 7, 8, 9 AND 14 (WITH ORIGINAL SIGNATURES ON PAGE 14).

IMPORTANT:

Please make a copy or copies of the completed document for your records. Once submitted, there may be a fee per page and waiting period for duplication services.

Click the following link to see samples of completed written collaborative agreements:

http://www.mbon.org/adv\_prac/sample\_agreements





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**NURSE PRACTITIONER WRITTEN AGREEMENT**

THE PURPOSE OF THIS AGREEMENT IS TO REFLECT THE UNDERSTANDING BETWEEN THE NURSE PRACTITIONER AND PHYSICIAN (S) AS RELATED TO THE ADVANCED PRACTICE ACTIVITIES OF THE NURSE PRACTITIONER AND THE NATURE OF THEIR MUTUAL COLLABORATION.

**SECTION I - GENERAL INFORMATION**

**A. NURSE PRACTITIONER INFORMATION**

NAME- AS IT APPEARS ON YOUR LICENSE	
HOME ADDRESS (STREET, CITY, STATE, ZIP CODE)	
HOME TELEPHONE #	
OFFICE TELEPHONE #	
CELL PHONE #	
EMAIL ADDRESS	
MARYLAND LICENSE #	
NURSE PRACTITIONER PROGRAM	
YEAR OF COMPLETION OF NP PROGRAM	
NATIONAL CERTIFYING ORGANIZATION	
ORIGINAL CERTIFICATION DATE	
AREA OF CERTIFICATION FOR THIS AGREEMENT	

**B. PHYSICIAN INFORMATION**

**PHYSICIAN # 1**

NAME-AS IT APPEARS ON THE LICENSE	
PRACTICE ADDRESS	
TELEPHONE #	
MARYLAND MEDICAL LICENSE #	
AREA OF CONCENTRATION OR SPECIALTY	

**PHYSICIAN # 2**

NAME-AS IT APPEARS ON THE LICENSE	
PRACTICE ADDRESS	
TELEPHONE #	
MARYLAND MEDICAL LICENSE #	
AREA OF CONCENTRATION OR SPECIALTY	

**PHYSICIAN # 3**

NAME-AS IT APPEARS ON THE LICENSE	
PRACTICE ADDRESS	
TELEPHONE #	
MARYLAND MEDICAL LICENSE #	
AREA OF CONCENTRATION OR SPECIALTY	

**PHYSICIAN # 4**

NAME-AS IT APPEARS ON THE LICENSE	
PRACTICE ADDRESS	
TELEPHONE #	
MARYLAND MEDICAL LICENSE #	
AREA OF CONCENTRATION OR SPECIALTY	

**PHYSICIAN # 5**

NAME-AS IT APPEARS ON THE LICENSE	
PRACTICE ADDRESS	
TELEPHONE #	
MARYLAND MEDICAL LICENSE #	
AREA OF CONCENTRATION OR SPECIALTY	

**PHYSICIAN # 6**

NAME-AS IT APPEARS ON THE LICENSE	
PRACTICE ADDRESS	
TELEPHONE #	
MARYLAND MEDICAL LICENSE #	
AREA OF CONCENTRATION OR SPECIALTY	



IF THERE ARE MORE THAN SIX (6) COLLABORATING PHYSICIANS, CHECK HERE, MAKE A COPY OR COPIES OF PAGE 4 AND PROVIDE PHYSICIAN INFORMATION FOR EACH ADDITIONAL PHYSICIAN. INSERT THE ADDITIONAL PAGE(S) AFTER THIS PAGE (PAGE 4) AND LABEL EACH ACCORDINGLY (4a, 4b, ETC.).

## C. NURSE PRACTITIONER PRACTICE

### 1. NURSE PRACTITIONER CERTIFICATION

- NEONATAL:** (Practice is limited to Birth to 1 Year)
- PEDIATRIC:** (Practice is limited to Birth to 21 Years)
- PEDIATRIC ACUTE CARE:** (Practice is limited to Birth to 21 Years)
- ADULT:** (Practice is limited to Age 16 and above)
- ACUTE CARE:** (Practice is limited to Age 16 and above)
- GERIATRIC:** (Practice is limited to Age 55 and above)
- FAMILY:** (No age limits)
- PSYCHIATRIC MENTAL HEALTH CHILD & ADOLESCENT:**  
(Practice restricted to ages 18 and below)
- PSYCHIATRIC MENTAL HEALTH ADULT:** (Practice restricted to Ages 16 and Above)
- PSYCHIATRIC MENTAL HEALTH FAMILY:** (No age limits)

- WOMEN'S HEALTH CARE NURSE PRACTITIONER/OB-GYN: NO MALE PATIENTS** (Practice is limited to women)

**EXCEPTION: REPRODUCTIVE HEALTH AND STD TREATMENT OF MALE PATIENTS PERMITTED, WITH THE APPROPRIATE COURSE WORK. CHECK BELOW IF YOU ARE SUBMITTING PROOF OF STD COURSE WORK.**

### 2. APPROXIMATELY (ON AVERAGE) HOW MANY PATIENTS WILL THE NP SEE DURING A DAILY WORK PERIOD?:

#### (a) CHECK ONE TIMEFRAME

- 8 - HOURS     10 - HOURS     12 - HOURS     16 - HOURS

#### (b) INDICATE APPROXIMATE NUMBER OF PATIENTS TO BE SEEN:

**3. INDICATE WHERE YOU WILL PRACTICE.**

AMBULATORY BASED PRACTICE	HOSPITAL BASED PRACTICE	OTHER SITES
<input type="checkbox"/> CLINIC	<input type="checkbox"/> INPATIENT AREA	<input type="checkbox"/> LONG-TERM CARE
<input type="checkbox"/> HOME	<input type="checkbox"/> CONTINUOUS CARDIAC MONITORING <i>(Acute Care NP's only)</i>	<input type="checkbox"/> NURSING REHAB CENTER
<input type="checkbox"/> PRIVATE OFFICE	<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> OUTPATIENT SURGICAL CENTER
<input type="checkbox"/> OTHER <i>(Describe):</i>		

**4. LIST NAME, ADDRESS AND TELEPHONE INFORMATION FOR THE SITE(S) WHERE YOU WILL PRACTICE.**

NAME OF HOSPITAL OR PRACTICE	ADDRESS	TELEPHONE #

NAME OF HOSPITAL OR PRACTICE	ADDRESS	TELEPHONE #

**5. FOR EACH PRACTICE SITE: DESCRIBE THE TYPE OF PRACTICE, THE PATIENT POPULATION, AND THE NURSE PRACTITIONER'S ROLE.**

<u>TYPE OF PRACTICE — SITE #1</u>	<u>TYPE OF PRACTICE — SITE #2</u>
<u>PATIENT POPULATION</u>	<u>PATIENT POPULATION</u>
<u>DESCRIPTION OF THE PRACTITIONER ROLE</u>	<u>DESCRIPTION OF THE PRACTITIONER ROLE</u>

<input type="checkbox"/> IF MORE THAN TWO (2) PRACTICE SITES, CHECK HERE, ATTACH A SEPARATE PAGE, AND LIST NAME, ADDRESS, TELEPHONE NUMBER, TYPE OF PRACTICE, PATIENT POPULATION AND NURSE PRACTITIONER'S ROLE INFORMATION FOR EACH ADDITIONAL SITE. INSERT THE ADDITIONAL PAGE(S) AFTER THIS PAGE (PAGE 6) AND LABEL EACH ACCORDINGLY (6a, 6b, ETC.).
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## SECTION II - DESCRIPTION OF NURSE PRACTITIONER FUNCTIONS

**A. NURSE PRACTITIONER DIAGNOSES LIST FOR PHYSICAL, MENTAL AND EMOTIONAL AILMENTS OR POTENTIAL AILMENTS**

*List examples of common diagnoses for patients seen in the practice setting(s)*

**B. DRUG PRESCRIPTIONS:**

**1. WILL YOU PRESCRIBE MEDICATIONS?**

**YES** (If yes, complete this page and the Medication List on page 9)

**NO** (if no, go to Page 10)

**2. WILL YOU PRESCRIBE CONTROLLED DANGEROUS SUBSTANCES (CDS)?**

**YES** (If yes, indicate examples of Schedule drugs on the Medication List on page 9)

(a) **MARYLAND DRUG CONTROL #**

Pending CDS License (*Send a copy of license to the Board when issued*)

Pending CDS License Renewal (*Send a copy to the Board when received*)

(b) **FEDERAL DEA #**

Pending DEA License (*Send a copy of license to the Board when issued*)

Pending DEA License Renewal (*Send a copy to the Board when received*)

**NO** (If no, indicate below how Controlled Dangerous Substances (CDS) will be prescribed in the practice and then proceed to Page 9.)

Prescribed by the Collaborator       Not Prescribed in this Setting

**Other** (explain):

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### C. LIST OF PRESCRIBED DRUGS

Provide 1 or 2 examples of drugs to be prescribed by the nurse practitioner:

CATEGORY	EXAMPLES
ANALGESICS/ NON-NARCOTIC AND NSAIDS	
ANALGESICS/NARCOTIC AND OPIOID	
ANESTHETICS, LOCAL	
ANTI-ANXIETY /DEPRESSANTS	
ANTIBIOTICS	
ANTIBACTERIALS	
ANTICOAGULANTS	
ANTIHYPERGLYCEMICS	
ANTIDIARRHEALS	
ANTIEMETICS	
ANTI-FUNGALS	
ANTIHELMINTICS	
ANTIHISTAMINES	
ANTIHYPERTENSIVES	
ANTI-INFLAMMATORIES	
ANTINAUSEANTS	
ANTITUBERCULARS	
ANTITUSSIVES & EXPECTORANTS	
ANTI-ULCER DRUGS	
ANTIVIRALS	
BRONCHODILATORS	
CALCIUM GLUCONATE	
CONTRACEPTIVES	
CORTICOSTEROIDS	
DECONGESTANTS	
DERMATOLOGIC PREPARATIONS	
EPINEPHRINE	
GASTROINTESTINAL	
HEMATINICS	
HEMORRHOIDAL PREPARATIONS	

CATEGORY	EXAMPLES
HORMONAL DRUGS AND PREPARATIONS	
HYPNOTIC/SEDATIVES	
IMMUNIZATIONS /BIOLOGICALS	
INTRAVENOUS FLUIDS AND ELECTROLYTES	
LAXATIVES	
MAGNESIUM SULFATE	
NASAL DRUGS /VASOCONSTRICTORS	
OPHTHALMIC, OTIC ANTI-INFECTIVES, ANTI-INFLAMMATORIES	
PEDICULOCIDES AND SCABICIDES	
RHO GAM	
SILVER NITRATE DROPS	
SMOKING CESSATIONS DRUGS	
STEROIDS-TOPICAL	
VAGINAL CREAMS	
VITAMINS AND MINERALS	
OTHER:	

<b>SPECIALTY DRUGS</b>	
<b>CATEGORY CHEMO THERAPEUTICS INITIAL ORDER BY ONCOLOGIST ONLY</b>	
<input type="checkbox"/>	REORDER ONLY (LIST)

**D. ORDERS LABORATORY AND/OR DIAGNOSTIC PROCEDURES:**  YES  NO

IF YES, CHECK ANY THAT APPLY		
<b>EXAMPLES:</b>		
<input type="checkbox"/> BLOOD TESTS	<input type="checkbox"/> URINE TESTS	<input type="checkbox"/> TESTS OF OTHER BODY FLUIDS
<input type="checkbox"/> X-RAYS	<input type="checkbox"/> CAT SCANS	<input type="checkbox"/> MRI
<input type="checkbox"/> ECGS	<input type="checkbox"/> EEGS	<input type="checkbox"/> MAMMOGRAMS
<input type="checkbox"/> DOPPLER STUDIES	<input type="checkbox"/> BIOPSIES	<input type="checkbox"/> OTHER: (LIST)
<input type="checkbox"/> COLONOSCOPIES	<input type="checkbox"/> SONOGRAMS	

**E. INTERPRETS SPECIAL LABORATORY AND/OR DIAGNOSTIC PROCEDURES:**  YES  NO

<i>If yes, list test(s) and procedure(s) and submit competency documents for each. (See page 15)</i>	
<p><b>NUMBER OF COMPETENCY FORMS ATTACHED:</b></p>	<input style="width: 50px; height: 20px;" type="text"/>

**F. PERFORMS DIAGNOSTIC AND THERAPEUTIC PROCEDURES:**  YES  NO

<i>Check all that apply and submit competency documents for each (see page 15)</i>	
<input type="checkbox"/> JOINT ASPIRATION	<input type="checkbox"/> PARACENTESIS
<input type="checkbox"/> ULTRA SOUND	<input type="checkbox"/> LUMBAR PUNCTURE
<input type="checkbox"/> THORACENTESIS	<input type="checkbox"/> ENDOMETRIAL BIOPSIES
<input type="checkbox"/> ABCESS DRAINAGE	<input type="checkbox"/> COLONOSCOPIES
<input type="checkbox"/> BIOPSIES	<input type="checkbox"/> OTHER PROCEDURES YOU WILL PERFORM (LIST)
~	
<p><b>NUMBER OF COMPETENCY FORMS ATTACHED:</b></p>	
<input style="width: 50px; height: 20px;" type="text"/>	

**G. EMERGENCY CARE:**

**1. WHAT IS THE PROCEDURE FOR ADDRESSING MEDICAL EMERGENCIES?**

**2. WHAT WILL BE THE NURSE PRACTITIONER'S ROLE OR RESPONSIBILITY IN A MEDICAL EMERGENCY?**

**CHECK ALL THAT APPLY**

**CALL 911/CODE TEAM**

**INITIATE BASIC LIFE  
SUPPORT (BLS)**

**PERFORM ADVANCED  
LIFE SUPPORT**

**3. INDICATE YOUR CURRENT CPR, PALS, NRP, AND/OR ACLS CERTIFICATION.**

**CPR:**     **YES**             **NO**            **EXPIRATION DATE:**

**ACLS:**     **YES**             **NO**            **EXPIRATION DATE:**

**PALS:**     **YES**             **NO**            **EXPIRATION DATE:**

**NRP:**      **YES**             **NO**            **EXPIRATION DATE:**

**ATTACH COPIES OF ALL CERTIFICATIONS**

**SECTION III - REFERRALS AND NURSE PRACTITIONER/PHYSICIAN COLLABORATOR RELATIONSHIP(S)**

- A. COLLABORATING PHYSICIAN(S) REFERRALS: PROVIDE EXAMPLES OF WHEN THE NURSE PRACTITIONER WILL CONSULT WITH THE COLLABORATING PHYSICIAN.**

- B. DOCUMENT NURSE PRACTITIONER AND PHYSICIAN ACCOUNTABILITY DESCRIBE THE PROCESS, METHOD, FREQUENCY, ETC., FOR JOINTLY SIGNING RECORDS TO DOCUMENT A COLLABORATIVE PLAN OF CARE.**

- C. REFERRALS TO APPROPRIATE LICENSED PHYSICIANS OR OTHER HEALTH CARE PROVIDERS: GIVE EXAMPLES OF TYPES OF SPECIALISTS OR OTHER PROVIDERS, SOMEONE OTHER THAN YOUR COLLABORATOR(S).**

- D. COLLABORATING PHYSICIAN(S) AVAILABILITY:**

AVAILABLE ON SITE

AVAILABLE BY PHONE OR OTHER METHOD OF TELECOMMUNICATION



# SECTION IV - AUTHORIZATIONS

**THE NURSE PRACTITIONER AND THE COLLABORATING PHYSICIAN(S) HEREBY AGREE TO DISCUSS PATIENT DIAGNOSES, REVIEW DRUGS AND OTHER BROAD MEDICAL PRACTICE GUIDELINES AT LEAST ANNUALLY.**

THE NURSE PRACTITIONER SHALL IMMEDIATELY NOTIFY THE NURSING BOARD IF THE WRITTEN AGREEMENT IS ENDED BY EITHER PARTY. THE PHYSICIAN(S) SHALL IMMEDIATELY NOTIFY THE MEDICAL BOARD IF THIS WRITTEN AGREEMENT IS ENDED BY EITHER PARTY. THE NURSE PRACTITIONER SHALL SUBMIT A NEW OR AMENDED WRITTEN AGREEMENT FOR APPROVAL BEFORE ALTERING THE PRACTICE SETTING OR MODIFYING OR EXPANDING THE MEDICAL FUNCTIONS THAT THE NURSE PRACTITIONER IS AUTHORIZED TO PERFORM. (AUTHORITY COMAR 10.27.07)

**ORIGINAL SIGNATURES AND THE DATE SHALL BE AFFIXED  
BY ALL PARTIES ENTERING INTO THIS AGREEMENT  
(ATTACH ADDITIONAL SIGNATURE PAGES IF NECESSARY)**

<b>NURSE PRACTITIONER</b>	
<i>Type or print name as it appears on your license</i>	
<i>Signature</i>	<i>Date</i>

<b>CHIEF OF SERVICE OR MEDICAL DIRECTOR</b>	
<b>(HOSPITALS ONLY — SEE STEP 6 OF INSTRUCTION MANUAL)</b>	
<i>Type or print name as it appears on your license</i>	
<i>Signature</i>	<i>Date</i>

<b>PHYSICIAN (S)</b> (PROVIDE PHYSICIAN INFORMATION ON PAGE 3 FOR EACH SIGNATURE BELOW)	
<b>PHYSICIAN #1</b>	
<i>Type or print name as it appears on your license</i>	
<i>Signature</i>	<i>Date</i>

<b>PHYSICIAN (S)</b> (PROVIDE PHYSICIAN INFORMATION ON PAGE 3 FOR EACH SIGNATURE BELOW)	
<b>PHYSICIAN #4</b>	
<i>Type or print name as it appears on your license</i>	
<i>Signature</i>	<i>Date</i>

<b>PHYSICIAN #2</b>	
<i>Type or print name as it appears on your license</i>	
<i>Signature</i>	<i>Date</i>

<b>PHYSICIAN #5</b>	
<i>Type or print name as it appears on your license</i>	
<i>Signature</i>	<i>Date</i>

<b>PHYSICIAN #3</b>	
<i>Type or print name as it appears on your license</i>	
<i>Signature</i>	<i>Date</i>

<b>PHYSICIAN #6</b>	
<i>Type or print name as it appears on your license</i>	
<i>Signature</i>	<i>Date</i>

**MAKE A COPY OF THIS ENTIRE AGREEMENT FOR YOUR RECORDS; MAIL ORIGINAL TO:**

ADVANCED PRACTICE DEPARTMENT  
MARYLAND BOARD OF NURSING  
4140 PATTERSON AVENUE  
BALTIMORE, MARYLAND 21215  
(410) 585-1930





(ADDENDUM)  
NEW PROCEDURE AND COMPETENCY CHECK LIST  
(SAMPLE FORM)

(TYPE) NURSE PRACTITIONER NAME:

TO OBTAIN APPROVAL FOR PROCEDURES NOT PREVIOUSLY APPROVED, YOU MAY USE THIS FORM TO DOCUMENT ANY NEW PROCEDURE(S) AND SUBMIT THEM TO THE BOARD. DO NOT INCLUDE A PROCEDURE ON THE WRITTEN COLLABORATIVE AGREEMENT UNTIL COMPETENCY HAS BEEN OBTAINED. ONCE COMPETENCY HAS BEEN OBTAINED, YOU MAY SUBMIT THIS FORM (OR ONE OF YOUR CHOOSING) TO THE BOARD FOR APPROVAL. THE BOARD DOES NOT ACCEPT COMPETENCY PAGES OR LETTERS ATTESTING TO PRACTITIONER COMPETENCY WITHOUT AN ACCOMPANYING WRITTEN AGREEMENT OR ADDENDUM.

TITLE OF PROCEDURE

EDUCATION PROGRAM/WORKSHOP DATE(S)

INSTRUCTOR

DATE	OBSERVED/ EVALUATED BY (SIGNATURE)	COMMENTS
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

I certify that \_\_\_\_\_ is able to perform the above procedure competently and independently.

(TYPE OR PRINT) EVALUATOR'S NAME EVALUATOR'S SIGNATURE & DATE TITLE  
(EVALUATOR MUST BE A PHYSICIAN OR NURSE PRACTITIONER)

(TYPE OR PRINT) COLLABORATOR'S NAME COLLABORATOR'S SIGNATURE

