STATE BOARD OF MEDICINE **Email:** st-medicine@pa.gov	**Phone** **717-783-1400/717-787-2381**

NURSE-MIDWIFE COLLABORATIVE AGREEMENT CHANGE FORM

The nurse-midwife shall notify the Board, in writing, of a change in 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 the collaborative physician/nurse-midwife relationship is a basis for disciplinary action against the nurse midwife's license.

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

* Upon filing of the requested changes, a confirmation email will be sent to the nurse-midwife at the email address on file with the Board.

INSTRUCTIONS – NURSE-MIDWIFE COLLABORATIVE AGREEMENT

1.	**CHANGES TO THE COLLABORATIVE AGREEMENT:** Complete Section A. **Submit a copy of the updated, signed collaborative agreement with this form**.
2.	**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 B. **Submit a copy of the updated, signed collaborative agreement with this form**.

INSTRUCTIONS – NURSE-MIDWIFE PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT	
1.	**CHANGES TO THE PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT**: Complete Sections C, D, and E. Submit **a copy of the updated, signed collaborative agreement with this form**.
2.	**CHANGE OF PRESCRIPTIVE AUTHORITY 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 must submit an application for an "Additional Prescriptive Authority Collaborative Agreement" through your PALS account at www.pals.pa.gov. • Complete Section B and E. **Submit a copy of the updated, signed collaborative agreement with this form**.

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.

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NURSE-MIDWIFE COLLABORATIVE AGREEMENT CHANGE FORM

SECTION A – 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**

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NURSE-MIDWIFE COLLABORATIVE AGREEMENT CHANGE FORM

SECTION B – 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**

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NURSE-MIDWIFE COLLABORATIVE AGREEMENT CHANGE FORM

PRESCRIPTIVE AUTHORITY COLLABORATIVE AGREEMENT

SECTION C – 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 D – 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 E – 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**