

Instructions for Collaborating Physician Commencement of Collaborative Practice

To commence a collaborative practice, the Collaborating Physician must submit a completed Commencement of Collaborative Practice form and \$200.00 commencement fee.

Effective June 14, 2021, also submit:

- **FTE disclosure form (see [Commencement of Collaborative Practice form](#))**
- **Collaborative practice quality assurance plan (copy of submission to Alabama Board of Nursing)**
- **Covering physician agreement (if applicable)**
- The non-refundable, non-transferable commencement fee may be paid by check or money order made payable to the Alabama Board of Medical Examiners and mailed with the signed, completed form.
- Limited protocol approvals are requested by separate application to the Alabama Board of Nursing.
- If the advanced practice nurse's application is not received from the Alabama Board of Nursing within six (6) months of submission of the Commencement of Collaborative Practice, the application will be withdrawn and no fees will be refunded.

Notice: Temporary approval to practice as a CRNP is issued solely by the Alabama Board of Nursing upon the CRNP's completion of the requirements for collaborative practice. This temporary approval only becomes effective upon submission and approval of the qualified physician's Commencement of Collaborative Practice form and receipt of the \$200 registration fee.

Qualifications for physicians in collaborative practice with CRNPs and CNMs:

- Current, unrestricted license to practice medicine in Alabama
- Practiced medicine for at least one year and AMA/AOA-approved specialty board certified OR practiced for at least three years

For additional information and forms, see www.albme.gov.



ALABAMA BOARD OF MEDICAL EXAMINERS
Commencement of Collaborative Practice

Website: www.albme.gov
Toll Free: 1-800-227-2606
Phone: 334-242-4116

Mailing Address:
P.O. Box 946
Montgomery, AL 36101-0946

Make \$200 Fee Payable to ALBME
Mail or Overnight to Physical Address

Physical Address:
848 Washington Avenue
Montgomery, AL 36104

Under Alabama law, this document is a public record and if requested it will be provided in its entirety

Physician's Name License #

Physician's Primary Practice Specialty

Physician's Primary Practice Address

Additional Corporate Address (if applicable)

CRNP/CNM Name RN License # Email

NP National Certification:

CRNP/CNM Primary Practice Address

Number of hours PER WEEK to practice in this Collaborative Agreement
(Cumulative total hrs for CRNPs/CNMs/PAs in all states may not exceed 360 hrs/week for each physician)

This practice is a physician primary practice remote practice site acute care hospital or
other facility licensed by the Dept of Public Health or Dept of Mental Health or N/A

This practice will be following a Limited Protocol Yes No

Limited Protocol for Comprehensive Physical Exam Long Term Care Facilities ADPH
(Applications for these protocols must be on file with the Alabama Board of Nursing)

Will this Collaborative Practice be solely by telemedicine? Yes No (If yes, the physician will
be sent a series of questions for which answers must be provided before processing of this
Commencement)

The physician's signature certifies that I the undersigned physician agree and/or confirm:

- 1. I have read and understand my responsibilities according to the Alabama Board of Medical Examiners
Rules, Administrative Rules Chapter 540-X-8, and Advanced Practice Nursing: Collaborative Practice.
2. All covering physician(s) listed in the application 1) have knowledge of their addition to this
Collaborative Agreement and 2) have an understanding of the Alabama Board of Medical Examiners
Rules, Administrative Rules Chapter 540-X-8, Advanced Practice Nursing: Collaborative Practice, and 3)
are aware of their responsibilities in this Collaborative Agreement.

Collaborating Physician must attest by check or initials the understanding all of the Quality Assurance Documentation
requirements by checking A, B and C:

- A. Documented Quality Assurance Reviews are required no
less than quarterly and shall be readily retrievable [540-X-8-.08 (7) (g)].
B. Physician and CRNP or CNM must review Quality Assurance data together
[540-X-8-.08 (7) (g)].
C. My signature on a patient record does not constitute Quality Assurance
documentation. [540-X-8-.01 (13)]

Physician Original Signature: [Signature Box] Date:



ALABAMA STATE BOARD OF MEDICAL EXAMINERS

William M. Perkins, Executive Director

Post Office Box 946
Montgomery, Alabama 36101-0946

Phone (334) 242-4116

**DISCLOSURE OF EXISTING SUPERVISORY
AND COLLABORATIVE AGREEMENTS**

In making an application for registration or a commencement for collaborative practice, the supervising or collaborating physician shall disclose to the Board of Medical Examiners the existence of all collaborative and supervisory agreements to which the physician is a party, including collaborative and supervisory agreements in other states. *See Ala. Admin. Rule 540-x-7-.26ER or Ala. Admin Rule 540-x-8-.12.*

Agreements with an individual certified registered nurse practitioner, certified nurse midwife, and/or assistant to physician in multiple states shall only be counted once for purposes of calculating the total number of full-time equivalent positions.

Are you currently collaborating with or supervising any combination of CRNPs, CNMs, and/or assistants to physicians?

YES NO

If **yes**, please complete the following:

<u>Name of Advanced Practice Provider</u>	<u>Principal Practice Location</u>	<u>Total hrs. per week</u>
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- 1.
- 2.
- 3.
- 4.
- 5.

This form should be completed by the supervising/collaborating physician and submitted with the application for registration of a physician assistant or the commencement of collaborative practice. Please attach additional pages if necessary.

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information, and belief.

Print Name

Signature

Date

DISCLOSURE OF EXISTING SUPERVISORY AND COLLABORATIVE AGREEMENTS

ADDITIONAL PAGE

<u>Name of APP</u>	<u>Principal Practice Location</u>	<u>Total hrs. per week</u>
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bme@albme.gov

COVERING PHYSICIAN AGREEMENT

As a covering (backup) physician providing oversight for
CRNP/CNM/PA (CRNP/CNM/PA or RA# _____), I hereby affirm that:

I will be readily available to collaborate with and provide medical oversight to the above-named advanced practice practitioner and, if indicated, to provide direct medical intervention to patients in the absence of the collaborating/supervising physician.

I am familiar with the current rules regarding Advanced Practice Nursing (Ala. Admin. Code Chapter 540-X-8)/Assistants to Physicians (Ala. Admin Code Chapter 540-X-7) and will abide by them.

I am familiar with the practitioner's standard protocols and any additional skills granted.

I will be accountable for adequate collaboration/supervision regarding the medical care rendered pursuant to the protocols and additional skills, if applicable.

I will approve the practitioner's prescribing of the drug types, dosages, quantities, and number of refills of legend drugs authorized in the standard formulary.

When the collaborating/supervising physician is not immediately available to respond to patient medical needs, the practitioner is not authorized to perform any act or render any treatments unless another qualified physician is **readily available to collaborate with/supervise the practitioner** and has previously filed with the Board this agreement.

During the temporary absence of the collaborating/supervising physician named below, I agree to assume those responsibilities for oversight and direction of the advanced practice practitioner enumerated in the collaboration/supervisory agreement with the collaborating/supervising physician.

Medical specialty of covering physician

Print Covering Physician Name

License #

Covering Physician Signature

Date

Covering Physician's Telephone Number

Fax

Collaborating/Supervising Phys. Name

Collaborating/Supervising Physician Lic. #