

## **Collaborative Practice Agreement with Data Waiver**

Advanced Practice Registered Nurses (APRNs) with Prescriptive Authority must have a current updated Collaborative Practice Agreement (CPA) on file with the Board of Nursing. APRNs should keep their original CPA and provide the Board with a copy submitted via fax, mail, or scanned/emailed. The APRN is responsible for ensuring this requirement is met.

The APRN must notify the Board in writing within seven (7) days after the CPA is terminated. If the Board does not have a current CPA on file, the APRN's Prescriptive Authority will be inactivated. When a new CPA has been approved by Board staff, Prescriptive Authority is reactivated. After approval of any new CPA, the APRN will be contacted by mail that the CPA has been approved and in effect.

The Collaborative Practice Agreement must meet the following criteria:

1. Must be complete and legible
2. The collaborating physician must have a current AR license to practice under the Medical Practice Act, § 17-95-201. The collaborating physician must also have an unrestricted DEA registration number for APRNs who prescribe controlled substances.
3. The collaborating physician's practice must be comparable in scope, specialty, or expertise to that of the APRN's practice/specialty.
4. Must include a statement that "APRN's prescribing will be limited to the area of educational preparation and certification."
5. Provision addressing availability of the collaborating physician for consultation and/or referral
6. Method of management of the collaborative practice (include a statement regarding protocols for Prescriptive Authority)
7. Plans for coverage of the health care needs of the patient in the emergency absence of the APRN or collaborating physician
8. Provision for quality assurance (attach the Quality Assurance Plan that has been signed by the APRN and the collaborating physician).
9. Signatures of both the APRN and the collaborating physician
10. If signatures are on a separate sheet from the agreement, a statement indicating that there is mutual agreement to the terms and conditions of the CPA must be included on the signature page (so that it is clear what the signature indicates).
11. License numbers and certification specialties of both the APRN and the collaborating physician
12. Address and phone number of the APRN's and physician's practice site(s)

# Collaborative Practice Agreement with a Single Physician – DATA 2000 Waiver

This agreement is for the management of the collaborative practice between

\_\_\_\_\_, APRN and \_\_\_\_\_, MD.

The physician hereby agrees to be available to the Advanced Practice Registered Nurse (APRN), either in person or via electronic or telephonic communication, for consultation and referral. Mutually agreed upon protocols for Prescriptive Authority will be utilized by the APRN as a guide for general categories of health states. The APRN shall limit prescribing to the area of educational preparation and certification as noted below.

Should an emergency arise, necessitating the absence of the APRN or the collaborating physician from patient care responsibilities, provision for comparable coverage shall be arranged at the first possible opportunity. Until that time, \_\_\_\_\_ with which the collaborating providers are associated, provides emergency services 24-hours daily for the clients of \_\_\_\_\_

(hospital)  
(clinic)

There is a written provision for quality assurance (attach the Quality Assurance Plan).

This agreement of professional collaboration is by no means intended as a business contract but rather as a document that fulfills the requirements for Prescriptive Authority as set forth in the *Arkansas Nurse Practice Act*. The signatures below signify agreement to the terms of the collaborative practice.

\_\_\_\_\_, APRN

APRN AR License # \_\_\_\_\_

Print name \_\_\_\_\_

Certification/Specialty \_\_\_\_\_

Practice Site \_\_\_\_\_

Practice Address \_\_\_\_\_  
(Street)

Date Signed \_\_\_\_\_

(City) (County) (Zip)

Practice Phone # \_\_\_\_\_

\_\_\_\_\_, MD

MD AR License # \_\_\_\_\_

Print name \_\_\_\_\_

Area of certification \_\_\_\_\_

Practice Site \_\_\_\_\_

Practice Address \_\_\_\_\_  
(Street)

Practice site same as APN

Date Signed \_\_\_\_\_

(City) (County) (Zip)