STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

ASSISTANT PHYSICIAN VERIFICATION OF COLLABORATIVE PRACTICE ARRANGEMENT

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
P.O. BOX 4, JEFFERSON CITY, MO 65102
FOR OVERNIGHT DELIVERIES
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COLLABORATING PHYSICIAN	COLLABORATING ASSISTANT PHYSICIAN
PHYSICIAN NAME (PRINT)	ASSISTANT PHYSICIAN NAME (PRINT)
PHYSICIAN LICENSE NUMBER	ASSISTANT PHYSICIAN LICENSE NUMBER
TELEPHONE NUMBER	TELEPHONE NUMBER
EMAIL ADDRESS	EMAIL ADDRESS
COMPLETE ADDRESS OF COLLABORATIVE PRACTICE LOCATION(S)	PREVIOUS COLLABORATING PHYSICIAN (NAME AND LICENSE NUMBER) *IF THIS IS A CHANGE IN SUPERVISORS
SPECIALTY/BOARD CERTIFICATION	PREVIOUS COLLABORATING PHYSICIAN (NAME AND LICENSE NUMBER) *IF THIS IS A CHANGE IN SUPERVISORS
As the collaborating physician and in accordance with Chapter 334 RSMo and the Board's rules, I certify that: • I will be supervising the above named assistant physician for the delivery of health care services within the assistant physician's scope of practice and consistent within each collaborating professional's skill, training, and competence and the skill and training of myself. (334.037.1 and 334.037.2(5)(a)) • I understand I am responsible at all times for the oversight of the activities of and accept responsibility for primary care services rendered by the assistant physician. (334.036.5) • I understand the collaborative practice agreement shall meet the requirements set forth in 334.037 and 20 CSR 2150-2.240 such as maintaining geographical proximity, reviewing charts and delegating controlled-substance prescriptive authority. • I understand the collaborative practice agreement shall limit the assistant physician to providing only primary care services and only in medically underserved rural or urban areas of this state or in any pilot project areas established in which assistant physician may practice; (334.036.2) • I will notify the Board of any change or termination of a collaborative practice arrangement within fifteen (15) days of such occurrence; **and** (20 CSR 2150-2.250(1) • I have reviewed this document with the above named assistant physician and have reviewed the Statutes, Rules and Regulations that govern the practice of assistant physicians in the State of Missouri, including but not limited to 334.036 - 334.038 and 20 CSR 2150-2.200 - 20 CSR 2150-2.260.	As the collaborating assistant physician and in accordance with Chapter 334 RSMo and the Board's rules, I certify that: • I will be collaborating with the above named physician, appropriate to my training and experience and will not practice beyond the scope of my training and experience nor my capabilities and training; (334.037.1 and 334.037.2(5)(a)) • I understand the collaborative practice agreement shall meet the requirements set forth in 334.037 and 20 CSR 2150-2.240 such as maintaining geographical proximity, reviewing charts and delegating controlled-substance prescriptive authority. • I understand the collaborative practice agreement shall limit me in providing only primary care services and only in medically underserved rural or urban areas of this state or in any pilot project areas established in which assistant physician may practice; (334.036.2) • I will notify the Board of any change or termination of a collaborative practice arrangement within thirty (30) days of such occurrence; **and** (20 CSR 2150-2.250(1) • I have reviewed this document with the collaborating physician listed above and have also reviewed the Statutes, Rules and Regulations that govern the practice of assistant physicians in the State of Missouri, including but not limited to 334.036 -334.038 and 20 CSR 2150-2.200 - 20 CSR 2150-2.260.
PHYSICIAN SIGNATURE	ASSISTANT PHYSICIAN SIGNATURE
DATE	DATE