

## APRN Collaborative Agreement – SAMPLE

*[Insert Name of Organization]*

### I. PRACTICE SETTING:

*[Describe the type of setting:*

- *Inpatient – Specify the department(s) included, a brief description of the types of patients, and the typical hours of operation.*
- *Outpatient – Specify the type of practice(s) and/or clinic(s) included, a brief description of the types of patients, and the typical hours of operation.]*

### II. SCOPE OF PRACTICE:

*[This section addresses the scope of practice, as defined by the education and training of the advanced practice registered nurse, the education and training of the supervising/collaborating physician, state law, and the organization's policy.]*

- A. Education and training requirements for the advanced practice registered nurse (APRN): *[List the education and training requirements.]*

*[The following is an example and should be modified to meet the state nurse practice act and other statutory requirements.]*

The APRN must possess a valid, unencumbered license as an APRN from *[insert state name]*. If prescriptive authority is delegated, the APRN must also have a valid prescriptive authority number from *[insert state name]*. If prescriptive authority for controlled substances is delegated, the APRN must also have a state permit and a DEA certificate or be able to use an institutional permit and number. Copies of these records must be maintained in the APRN's personnel file.

- B. Certification and experience required of the (supervising/collaborating) provider: *[List the required information. The information may be found in a job description, credentialing policies, or privileging documents.]*

- C. Scope of practice as defined by *[insert state name]*:  
*[Cite information from the state's APRN licensing rules and regulations.]*

- D. Scope of practice as defined by *[insert name of organization]*:  
*[State the scope of practice for the APRN as defined by the organization.]*

*[The following is an example and should be modified to meet the state nurse practice act and other statutory requirements.]*

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The APRN will be responsible for providing health services to clients of *[insert organization name]*. The APRN will provide health promotion, screening, safety instructions, and management of acute episodic illness and stable chronic diseases. Referrals will be made, as needed, to other healthcare providers or specialists. Competencies may include the following:

- Elicit and record physical and mental health status and psychosocial history, including a review of bodily systems.
- Perform physical examinations.
- Initiate appropriate diagnostic tests for screening or evaluate the patient's current health status.
- Assess findings of the history, review of systems, physical examination, and diagnostic tests, and formulate a diagnosis prior to implementing a treatment regimen.
- Identify health problems and learning needs.
- Plan, teach, promote, and manage physical and mental healthcare in a continuous patient-centered and holistic program.
- Implement and manage treatment regimens and administer, prescribe, and dispense pharmacological agents.
- Arrange appropriate referrals.
- Initiate appropriate emergency treatment in life-threatening or unusual situations in order to stabilize the patient.
- Provide other functions common to the APRN role and for which the APRN is educationally and experientially prepared.

### E. Physician Consultation

*[The following is an example and should be modified to meet the state nurse practice act and other statutory requirements.]*

Physician consultation will be sought for all of the following situations and any others deemed appropriate:

- Whenever situations arise that go beyond the competence, scope of practice, or experience of the APRN.
- Whenever the patient's condition fails to respond to the management plan within an appropriate time frame, based on the provider's clinical judgment.
- For any uncommon, unfamiliar, or unstable patient condition.
- For any patient condition that does not fit the commonly accepted diagnostic pattern for a disease and/or condition.
- For any unexplained physical examination or historical finding, or abnormal diagnostic finding.
- Whenever a patient requests a consultation.
- For all emergency situations, after initial stabilizing care has been initiated.

Whenever a physician is consulted, a notation to that effect, including the physician's name, must be recorded in the patient's medical record.

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## APRN Collaborative Agreement – SAMPLE

### III. Supervision/Collaboration: *[Briefly describe the process.]*

#### A. (Supervising/Collaborating) Physician Responsibilities:

##### 1. Availability:

*[Describe the type of access – Will the provider be available on the campus, in the department, in the building? Will the provider be accessible by phone or pager when off-site? In a multiple supervisory/collaborative arrangement, will a schedule for supervision be provided?]*

##### 2. Evaluation of Clinical Care:

*[The following is an example and should be modified to meet the state nurse practice act and other statutory requirements.]*

Evaluation of the APRN's clinical actions will be provided in the following ways:

- Initial oral or written review of the first month of collaborative practice.
- Review of charts for patients seen by the APRN, reflecting a minimum of 10% of patient medical records and/or a bi-weekly discussion and review of care provided.
- Informal evaluation during consultations and case review.
- Periodic medical record reviews, as needed.

#### B. Coverage:

*[Describe the process for secondary supervision when the primary supervising physician is not available.]*

#### C. Supervision of Tasks Outside the Scope of Practice for the Primary Supervising/Collaborating Physician:

*[Clearly specify which, if any, tasks the APRN may perform that are outside the scope of practice of the primary supervising physician.]*

### IV. PRESCRIBING AUTHORITY:

*[Include state APRN licensing rules and regulations, as well as DEA guidelines.]*

*[The following is an example and should be modified to meet the state nurse practice act and other statutory requirements.]*

The APRN may prescribe controlled substances as indicated below (except for any prohibited medications that have been specified):

\_\_\_ Full Schedule II narcotics controlled substances **OR**

\_\_\_ Schedule II narcotics for acute pain, no refills

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## APRN Collaborative Agreement – SAMPLE

\_\_\_ Schedule II (non-narcotic) controlled substances for ADD treatment

\_\_\_ Schedules III-V controlled substances

\_\_\_ Prohibited Medications: Specify \_\_\_\_\_

- V. **PERFORMANCE EVALUATION:** Performance evaluations are conducted at least annually.  
*[Specify what is to be included in a performance evaluation (e.g., clinical care delivery, patient relations, professionalism, documentation review, and prescriptive practices). If the prescribing of controlled substances is permitted, pay special attention to this area, including a review of prescription monitoring program reports. Specify how the review will be documented.]*
- VI. **TERMINATION OF AGREEMENT:** Either party may terminate this practice agreement without cause at any time, effective immediately upon appropriate notice to the other party, etc.
- VII. **ATTESTATION:** The APRN and the primary (supervising/collaborating) physician acknowledge they have reviewed this document and agree to abide by its terms and conditions.

\_\_\_\_\_  
Printed Name of APRN

\_\_\_\_\_  
APRN Signature

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

\_\_\_\_\_  
Printed Name of Primary (Supervising /Collaborating) Physician

\_\_\_\_\_  
Primary (Supervising/Collaborating) Physician Signature

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

This document, or a reasonable substitute, must be maintained at the APRN's place of practice.

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## APRN Collaborative Agreement – SAMPLE

The attached *Advanced Practice Registered Nurse and Primary Supervising Physician Collaborative Agreement* for [insert name of APRN] has been reviewed and agreed to by the following secondary supervising/collaborating physician(s):

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Printed Name

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Signature

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Date Signed

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Printed Name

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Signature

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Date Signed

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Printed Name

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Signature

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Date Signed

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Printed Name

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Signature

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Date Signed

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