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STATE OF DELAWARE

OFFICE OF CONTROLLED SUBSTANCES

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ALTERNATE COLLABORATING PHYSICIAN FORM

Instructions – This section is to be completed by the alternate collaborating physician(s). The physician assistant (PA) is required to upload this form with the application *or* renewal in DELPROS.

APPLICANT INFORMATION – *To be completed by the physician assistant applicant.*

1. Application Number: **APP–**_____ OR License Number: **DA–**_____

2. Physician Assistant Name: _____ _____ _____
First Name Middle Int. Last Name

ALTERNATE COLLABORATING PHYSICIAN INFORMATION – *To be completed by the collaborating physician.*

Printed Name of Physician:_____ and Specialty: _____

Name of Primary Practice: _____

Location of Primary Practice: _____ _____ DE _____
Street (No PO Box!) City Zip

Physician License Number: ____ - _____ and DE CSR Number: ____ - _____

Federal DEA Number: _____ Schedules the PA is authorized to prescribe: ☐ II ☐ III ☐ IV ☐ V

Are you delegating authority to request and issue professional controlled legend medication samples? Yes ☐ No ☐

Signature of Collaborating Physician _____ Date _____

ALTERNATE COLLABORATING PHYSICIAN INFORMATION – *To be completed by the collaborating physician.*

Printed Name of Physician:_____ and Specialty: _____

Name of Primary Practice: _____

Location of Primary Practice: _____ _____ DE _____
Street (No PO Box!) City Zip

Physician License Number: ____ - _____ and DE CSR Number: ____ - _____

Federal DEA Number: _____ Schedules the PA is authorized to prescribe: ☐ II ☐ III ☐ IV ☐ V

Are you delegating authority to request and issue professional controlled legend medication samples? Yes ☐ No ☐

Signature of Collaborating Physician _____ Date _____

UPLOAD THIS DOCUMENT WITH YOUR APPLICATION OR RENEWAL IN DELPROS