CANNON BUILDING
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STATE OF DELAWARE

OFFICE OF CONTROLLED SUBSTANCES

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EMAIL: customerservice.dpr@delaware.gov

MAIN COLLABORATING PHYSICIAN FORM

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

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

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

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

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

3. Printed Name of Collaborating Physician:_____

4. Collaborating Physician Specialty: _____

5. *Name* of Primary Practice: _____

6. *Location* of Primary Practice: _____
Street (No PO Box!)

_____ DE _____
City State Zip

7. Collaborating Physician License Number: ____ - _____

8. Collaborator DE CSR Number: ____ - _____ Federal DEA Number: _____

9. Schedules the PA is authorized to prescribe: ☐ II ☐ III ☐ IV ☐ V

10. 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