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STATE OF DELAWARE

BOARD OF NURSING

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COLLABORATIVE AGREEMENT

INSTRUCTIONS

A collaborative agreement is required for Advanced Practice Registered Nurse (APRN) practice in Delaware *only if* the APRN has practiced as an APRN less than two years *or* fewer than 4,000 hours.

- Upload this document with your application or the Service Request *Collaborative Agreement Change* in DELPROS for *each new or additional collaborator.*
- The APRN must sign the top box. The collaborator/designee at this business/practice must sign the **CERTIFICATION OF COLLABORATIVE AGREEMENT** below it.

BUSINESS/PRACTICE INFORMATION - *To be completed and signed by APRN*

1. APRN Name: ____ Delaware License: L ___ - ______________
2. Business/Practice Name: ____
3. ***Location*** Address: ____
   (If more than one location, enter main location. *No PO Box!)*

   ____ DE ______________ Business Phone: ________________
   City State Zip
4. Name of Collaborator at this Business/Practice: ____
5. Select the item that describes your collaborative agreement at this business/practice (check all that apply):
   - ☐ A - I have healthcare facility approved clinical privileges.
   - ☐ B - I have a healthcare facility approved job description.
   - ☐ C - I have a written agreement with a physician, podiatrist, or licensed Delaware healthcare delivery system.
6. Will you be prescribing controlled substances at any location of this business/practice? Yes ☐ No ☐
7. Do you agree to report to the Board office any changes in the person, facility or healthcare system with which you have a collaborative agreement? Yes ☐ No ☐

I affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

Signature of APRN: ____ Date: _________________

CERTIFICATION OF COLLABORATIVE AGREEMENT - *To be completed and signed by collaborator/designee*

I certify that a process for consultation and referral of clients has been established with the APRN named above. I understand that this agreement remains in place until either the APRN or collaborating practitioner/health care system notifies the Delaware Board of Nursing in writing that the collaborative agreement is terminated.

Signature: ____ Date: _______________

Print Name of Person Certifying to the Collaborative Agreement: ____

Are you a Delaware-licensed physician or podiatrist? Yes ☐ No ☐

- If yes, enter your Delaware License No: _____________________________
- If no, enter title and healthcare system you represent: ____