CANNON BUILDING
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DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF NURSING

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ADVANCED PRACTICE REGISTERED NURSE
REPORT OF COLLABORATIVE AGREEMENT CHANGE

INSTRUCTIONS

When You Need a Collaborative Agreement

To practice as an APRN in Delaware, you must have a collaborative agreement ***only if*** you have practiced as an APRN less than two years ***or*** fewer than 4,000 hours. If you are required to have a collaborative agreement, you are *not allowed to start practicing* as an APRN in Delaware until your APRN license (or a temporary permit has been issued) ***and*** you have obtained the collaborative agreement.

When to Use this Form

Use this form when you have applied for or already hold a Delaware APRN license, you are required to have a collaborative agreement as explained above, ***and*** any of the following applies:

- A collaborative agreement has terminated.
- You had no collaborative agreement when you applied for received your APRN license, but you now have an agreement.
- You need to report a new or additional collaborative agreement or any other collaborator change.

If you have not yet applied for your Delaware APRN license, see *Application for Licensure as an Advanced Practice Registered Nurse*.

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____ _____
   Last First Middle Maiden

2. Do you hold an active Delaware APRN license? Yes ☐ No ☐ If yes, license number: L ____ - _____

3. If you did not enter a license number above, enter your Social Security Number: _____

4. Address: _____

   _____ _____ _____
   City State Zip

5. Phone: _____ _____ Email: None ☐ _____
   daytime evening or cell

END OF AGREEMENT

6. Are you reporting the end of a collaborative agreement? Yes ☐ No ☐ **If no, skip to the NEW OR ADDITIONAL AGREEMENT section. If yes, enter the following information about the *terminated* agreement:**

   Name of Former Collaborator: _____

   Business/Practice Name: _____

   Business/Practice Address: _____

   Why did the agreement terminate?

   ☐ I am no longer employed at this business/practice.

   ☐ My former collaborator is no longer employed at this business/practice.

   ☐ Other – explain: _____

Do you still have a collaborative agreement with someone else at this business/practice? Yes ☐ No ☐

If yes, who? _____

Did you previously report a collaborative agreement with this person? Yes ☐ No ☐ **If no, continue with the next section.**

NEW OR ADDITIONAL AGREEMENT

7. Are you reporting one or more new or additional collaborative agreements? Yes ☐ No ☐ **If no, skip to Question 9. If yes, complete the following information about the new or additional agreement(s). Check all that apply:**

   ☐ I did not have a collaborative agreement when I applied for APRN licensure, but I now have a new collaborator(s).

   ☐ I did not have a collaborative agreement when my APRN license was issued, but I now have a new collaborator(s).

   ☐ I have begun practicing at an *additional* business/practice and have a new collaborator there.

   ☐ I am practicing at the same business/practice I previously reported, but my collaborator there has changed.

   ☐ Other - explain: _____

8. Complete the following information about the each individual business/practice where you have a new, additional or revised collaborative agreement. Do ***not*** list multiple locations of the same business/practice. *If you need more room, enclose a separate sheet with the same information.*

DELAWARE BUSINESS/PRACTICE NAME	BUSINESS/PRACTICE ADDRESS

Submit a completed and signed *Collaborative Agreement* form from *each* new or additional collaborator.

9. 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 Advanced Practice Registered Nurse: _____ Date: _____

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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.

- Submit a completed and signed *Collaborative Agreement* form from *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 _____ _____
   City State Zip Business Phone
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: _____