



**STATE OF WEST VIRGINIA
BOARD OF EXAMINERS FOR REGISTERED PROFESSIONAL NURSES**

90 MacCorkle Ave., SW, Suite 203
South Charleston, WV 25303

DISSOLVEMENT/TERMINATION OF COLLABORATIVE AGREEMENT

NAME OF APRN: _____
PRINT

RXA NUMBER: _____

LICENSE NUMBER: _____

DEA NUMBER: _____

COLLABORATIVE AGREEMENT DISSOLVED EFFECTIVE: _____
DATE

Name of Collaborative Physician: _____ MD DO
PRINT

Business Address: _____

City, State, Zip Code: _____

Business Phone: _____

West Virginia Medical License Number: _____

Reason for dissolution of collaborative agreement: _____

Prescriber's Signature: _____ Date: _____

**NOTICE: You must also fill out a Prescriptive Authority Change Application
in your Nurse Portal account before this form can be processed.**

SUBSCRIBED AND SWORN TO BEFORE ME this _____ day of _____ 20____

STATE OF _____

COUNTY OF _____

(SEAL)

Signature of Notary Public _____

My Commission Expires: _____