WEST VIRGINIA BOARD OF REGISTERED NURSES
5001 MacCorkle Avenue SW
South Charleston, WV 25309

THIS FORM MAY SERVE AS AN ACTUAL COLLABORATIVE AGREEMENT OR AS A VERIFICATION OF COLLABORATIVE AGREEMENT FOR PRESCRIPTIVE AUTHORITY PRIVILEGES. APPLICANTS MAY USE THIS FORM ALONE OR COMPLETE THIS FORM AND ATTACH ADDITIONAL PAGES.

(Complete for each collaborative physician)

Both I and the below named physician have read and understand the regulations pertaining to prescriptive writing privileges (Federal and State prescribing laws including West Virginia Code for Registered Professional Nurses (30-7-15 a, b, and c; and West Virginia Legislative Rule 19CSR8). We, the undersigned APRN and Physician verify by our signatures below that we have entered into a written collaborative agreement and that written guideline/protocols for prescriptive practice are signed and in place as detailed below:

Name of APRN:_____

Signature of APRN:_____

Name of Physician:_____

Signature of Physician:_____

Collaborative Agreement effective date is: _____.

1. **Mutually agreed upon written guidelines or protocols for prescriptive authority as it applies to the APRN's prescriptive practice. I have listed below the guidelines and protocols used in my practice.**

_____
_____

_____

_____
_____

2. **Statements describing the individual and shared responsibilities of the APRN and the physician pursuant to the collaborative agreement between them are listed below:**

_____
_____

_____

_____
_____

3. Periodic and joint evaluation of prescriptive practice will occur as listed below:

Frequency of record review _____ Number of records reviewed _____

4. Periodic and joint review and updating of the written guidelines or protocols will occur

_____**(frequency)**.

PLEASE NOTE: IF YOU HAVE **CURRENTLY ACTIVE** PRESCRIPTIVE AUTHORITY, YOU MUST ALSO FILL OUT A PRESCRIPTIVE AUTHORITY CHANGE APPLICATION IN YOUR NURSE PORTAL ACCOUNT BEFORE THIS FORM CAN BE PROCESSED. **THIS DOES NOT APPLY TO INITIAL APPLICANTS.**

This agreement shall only be in effect as long as the parties agree to perform the duties outlined herein and there is no change in status of the registered nursing license, the advanced practice license or the prescriptive authority privilege of the advanced practice registered nurse or the license of the collaborative physician. This agreement will no longer be in effect if any of the following changes in status occur:

a. If the licensure status of either party changes due to discipline;
b. If any licensure status of either party changes due to failure to renew or reinstate a license;
c. If the licensure status of the advanced practice registered nurse changes due to failure to meet certification standards and notify the Board of such; or
d. Any other action outlined in rule or statute that may affect licensure status.

I further understand that I must ensure that current information regarding collaborative agreement(s) is **on file at the Board office.** I understand that I **must have at least one current collaborative agreement verification on file** at the Board office at all times. When my collaborative agreement is no longer valid (i.e. dissolvement of agreement, agreement not renewed, termination of my employment), I understand that I am to notify the Board office **immediately**. I further understand that my prescribing privileges are for practice only in the state of West Virginia and that my prescribing practice may be audited/reviewed by the Board. I will practice according to Federal and State Law, the standards of practice in my specialty area, my education and documented competence.

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APPLICATION PAGE

Furthermore, I, the undersigned, being duly sworn, according to law, do depose and say that I am the person making this application; that the statements therein are true to the best of my knowledge and belief; that I have read and understand the Law and Rule pertaining to prescriptive authority; I understand that failure to comply with requirements for licensure, and that knowingly supplying false information on or with this verification is a violation of WV Code §30-7-1 et. seq. and subjects me to the full range of disciplinary action described therein.

Name of Applicant: _____ **License Number** _____
PRINT

Practice Address: _____

_____

_____

Phone: _____ Fax: _____ Email: _____

Name of Physician:_____ □**MD** □**DO License Number** _____
PRINT

Practice Address: _____

_____

_____

Phone: _____ Fax: _____ Email: _____

APRN Signature _____ **Date**_____

SUBSCRIBED AND SWORN TO BEFORE ME this _____day of _____ 20_____

STATE OF_____
COUNTY OF_____ **(SEAL)**

Signature of Notary Public _____

My Commission Expires: _____