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

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 dissolvement 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: _____