ALABAMA STATE BOARD OF MEDICAL EXAMINERS
848 Washington Avenue (36104)
P.O. Box 946, Montgomery, AL 36101-0946
(334) 242-4116

The Collaborating Physician is required to submit the following form and fee for the Registration and Commencement of Collaborative Practice to the Alabama Board of Medical Examiners

1. The following information is required and form will be returned if incomplete:
   a. Physician's name, license number and practice address
   b. CRNP/CNM name, license number and practice address.
   c. Completion of the Quality Assurance Plan
2. Original Signature of the Collaborating Physician attesting to the required information.
3. Remittance of Collaborative Practice Fee of $100.00 payable to: Alabama Board of Medical Examiners.

Notice: Until this Commencement Form and Fee are received this Collaborative Agreement will NOT be issued Temporary Approval by the Alabama Board of Nursing.

540-X-8-.04 Qualifications for Physicians in Collaborative Practice with Certified Registered Nurse Practitioners

(1) The physician in collaborative practice with a certified registered nurse practitioner shall have:

(a) A current, unrestricted license to practice medicine in the State of Alabama; and

(b) Practiced medicine for at least one year, if the physician is certified by or eligible for board certification by a specialty board approved by the American Medical Association or by the American Osteopathic Association; or have practiced medicine (for CNM's including the active practice of obstetrics and /or gynecology), for at least three years.

(c) Paid all collaborative practice fees due to the Board of Medical Examiners and submitted to the Board of Medical Examiners a Commencement of Collaborative Practice form. In the event no application is received from the Alabama Board of Nursing within six (6) months of submission, the submitted form will be withdrawn by the Board. The fee submitted with the Commencement of Collaborative Practice form is non-refundable and non-transferable.

ALABAMA BOARD OF MEDICAL EXAMINERS

Commencement
For Collaborative Practice

Mailing Address:
P.O. Box 946
Montgomery, AL 36101-0946

Physical Address:
848 Washington Avenue
Montgomery, AL 36104

Phone: 334-242-4116
Toll Free: 1-800-227-2606
Website: www.albme.org

****Send this signed *original* document and $100.00 fee to the Alabama Board of Medical Examiners.**

Alabama Board of Medical Examiners
Attn: Collaborative Practice Department
Phone: 334-242-4116

(Use one page per CRNP/CNM. Make additional copies as needed)

1. **Physician's Name:______________________________License Number:________________**
2. **Practice Address:____**
3. **CRNP/CNM Name:_____________________________License Number:________________**
4. **CRNP/CNM Practice Address: ____**
5. **Date services to begin under this Collaborative Agreement ___________________________**

This is to certify that I, the undersigned physician agree and/or confirm:

1. **The nurse practitioner/nurse mid-wife above and I will complete chart reviews for Quality Assurance as per the plan below and agree that 100% of all adverse actions will be reviewed for Quality Assurance.**
2. **The covering physicians listed in the application have knowledge and understanding of the Collaborative Practice Rules [Chapter 540-X-8] and are aware of their responsibilities.**
3. **Have an emergency plan/ policy in writing at the practice site.**

Quality Assurance Plan:

A. **Who will complete the chart reviews? ___Physician __Nurse Practitioner __Other**
B. **What is the time frame for your review? ___Weekly ____Monthly ____Quarterly**
C. **Selection of records for review to include records for patients treated by the CRNP/CNM**
D. **Describe criteria for selecting records to be reviewed (give detail):**

I the undersigned physician have read and understand the Alabama Board of Medical Examiners Rules, *Chapter 540-X-8, and Advanced Practice Nursing: Collaborative Practice*. It is also understood that my signature attests to these facts. Failure to adhere to these rules may result in an action against my license. It is also understood that I will complete written Termination upon the dissolution of this Collaborative Agreement.

PHYSICIAN'S SIGNATURE: ______________________________DATE: _____________
(Original Signature Only)

Print Physician Name: ____DATE: _______________

****To alleviate a delay in approval of the Collaborative Practice fill out the form completely and send upon submission of the application to the Board of Nursing. This Commencement Form will be returned if all of the information is not present and a check attached for the required fee.**