



## INSTRUCTIONS:

### ADD OR CHANGE COLLABORATIVE PRACTICE FOR CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) OR CERTIFIED NURSE MIDWIFE (CNM)

1. This application form is specifically for the applicant who has previous approval by the Alabama Board of Nursing for practice as a CRNP or CNM, or has a pending application in progress.
2. Use this application to:
  - A. Add a collaborating physician. Submit a separate application for **each additional collaborating** physician.
  - B. Make changes in your currently approved protocol with an approved collaborating physician. This application replaces the previously approved protocol. Fill in all sections of the application.
3. Use the **Application to Add or Delete Covering (Back-Up) Physician** (no fee) if that is the only change to be made. Print the blank form at [www.abn.state.al.us](http://www.abn.state.al.us) > Applications.
4. Current licensure as a Registered Nurse in Alabama is required for approval to practice as an advanced practice nurse and for subsequent renewal of APN approval. Submit the **Application for Reinstatement of Lapsed License** if your RN license has Lapsed. Submit the application for **Reinstatement of Advanced Practice Nursing** if your RN license is Active and your APN approval has not been renewed for the current license period.
5. The requirements for Advanced Practice Nursing – Collaborative Practice as CRNP and CNM are posted: [www.abn.state.al.us](http://www.abn.state.al.us) > Nurse Practice Act > Article 5 Advanced Practice Nursing, and  
> Alabama Board of Nursing Administrative Code > Chapter 610-X-5 Advanced Practice Nursing – Collaborative Practice, and Chapter 610-X-2-.05 Definitions, Advanced Practice Nursing.  
These regulations are jointly adopted with the Alabama Board of Medical Examiners, Administrative Rules for physicians, Chapter 540-X-8 Advanced Practice Nursing [www.albme.org](http://www.albme.org)
6. Send **\$50.00 fee payable to the Alabama Board of Nursing with each complete application to Add or Change Collaborative Practice**. Refer to Alabama Administrative Code Chapter 610-X-4-.13 for restrictions on forms of payment.  
Application fees are not refundable. Applicants or licensees who have a check returned due to insufficient funds may be prohibited from paying any future fees by personal check. A fee of \$30.00, as allowed by Alabama statute, will be charged for a bad check.
  - A. **Acceptable forms of payment:**
    - (1.) Money order or certified check
    - (2.) Business or corporate check.
    - (3.) The applicant's personal check printed with the applicant's name, address and account number on an in-state Alabama bank.
  - Unacceptable forms of payment:**
    - (1.) Personal check on Out-of-state bank account.
    - (2.) Personal check that is not printed with the applicant's name, address and account number; example: a third party paying the applicant's fee.
    - (3.) Counter check
7. **The Collaborating Physician is required to notify the Alabama Board of Medical Examiners** within five (5) business days of commencing or terminating collaborative practice with a CRNP or CNM. The **Physician's Notice for Commencement of Collaborative Practice** is the last page in this form. Send the single page to the Alabama Board of Medical Examiners with payment of the Physician's Collaborative Practice annual fee (\$100.00). The physician is required to have an unencumbered Alabama medical license.
8. The CRNP/CNM applicant is responsible for the truth and accuracy of the completed application. Print legibly in black ink or type the required information on this form. Illegible or incomplete applications will be returned along with the fee/check/money order to the CRNP/CNM applicant.
9. **Send the signed original application** to the Alabama Board of Nursing. **Keep a copy** of the completed application for your records. The Board of Nursing charges a fee for copies of documents on file.

10. Include the name and license number of the CRNP/CNM and the collaborating physician on every page and attachment.
11. If you want verification of delivery to the Alabama Board of Nursing, please request this service from the US Postal Service or letter delivery service (FedEx, DHL, etc.) before you mail the application. The volume of incoming mail makes it impractical to respond to phone calls for immediate confirmation of mail delivery.

<p><b>Send the signed original application and supporting documents with \$50.00 payable to:</b></p> <p>Alabama Board of Nursing P. O. BOX 303900 Montgomery AL 36130-3900</p>	<p>Express Delivery should be addressed to:</p> <p>Alabama Board of Nursing 770 Washington Ave, Suite 250 Montgomery AL 36104-3816</p>
--	--

**NOTE:** Items sent by US Postal Service Certified, Express or Overnight service to P. O. BOX 303900 which require signature upon delivery will be documented in the central State of Alabama mailroom prior to delivery to the Alabama Board of Nursing staff.

12. The Alabama Board of Nursing processes applications in the order they are received (“first in, first out”). Allow at least two weeks for a response to your application.
13. Continued specialty certification is required to maintain approval for advanced practice nursing. It is the applicant’s responsibility to have the certifying agency send official verification of recertification to the Alabama Board of Nursing.
14. Temporary Approval. All applications are reviewed for Temporary Approval, as defined in Alabama Board of Nursing Administrative Code 610-X-5-.07 (CRNP) and 610-X-5-.17 (CNM). After the application meets all requirements, the Board of Nursing will send written verification of Temporary Approval to the applicant CRNP/CNM and the collaborating physician, to the current address on file with the Alabama Board of Nursing.
15. Applications that qualify for Temporary Approval are listed for review at the next scheduled meeting of the Joint Committee of the Alabama Board of Nursing and Alabama Board of Medical Examiners. Scheduled meeting dates are posted on the website of the Alabama Secretary of State [www.sos.state.al.us](http://www.sos.state.al.us) > Open Meetings Act.

<p>This tentative schedule is provided for planning purposes only. Adjustments to this schedule may occur at the discretion of the Board of Nursing.</p>	
If Temporary or Interim Approval is issued by this date or the last business day prior to:	The application will be posted for review at the next scheduled meeting:
February 15, or earlier	March
April 15, or earlier	May
June 15, or earlier	July
August 15, or earlier	September
October 15, or earlier	November

16. Notice of Approval for Practice will be mailed to the applicant’s **address of record on file** with the Alabama Board of Nursing. A copy is mailed to the physician. **Mail from the Alabama Board of Nursing is not forwarded by the US Postal Service.** If the letter to the CRNP/CNM or physician cannot be delivered as addressed, it is returned to the Board of Nursing. The Board charges a fee of \$25.00 to re-mail a document if returned by the USPS because the letter could not be delivered as addressed.
17. The RN shall notify the Board office in writing of any change in the licensee’s address. The address of record is the address provided by the applicant or licensee. The RN may update his or her personal mailing address and record name changes on the ABN website [www.abn.alabama.gov](http://www.abn.alabama.gov) > On-Line Services. For name changes, submit a copy of the court order, marriage license or divorce decree authorizing the change in your name.

18. **Exemptions from Collaboration with an Alabama physician** are allowed for two situations:

- A. Faculty in a nurse practitioner education program. Submit page 1 and page 9 of the application. Request confirmation of faculty status on institutional letterhead from the Dean/Program Director, mailed to the Alabama Board of Nursing.
- B. CRNP or CNM employed in a federal facility. Provide verification of medical license from the collaborating physician's state of licensure. Submit all sections of the application and protocol, page 1 – 8, and page 9 Request for Exemption.

**SECTIONS OF THE COLLABORATION PROTOCOL** (Pages 2 – 8 of this application)

- A. **Employer:** List the name and full address of the employer. (Page 2)
- B. **Physician Information.** (Page 2) Complete all items. Mark N/A if it does not apply. Example: Some medical specialty certifications do not issue a certificate number.

**Limit on CRNPs/CNMs/PAs per Physician.** List the names and **scheduled working hours** per week for all CRNPs, CNMs, and PAs, including other pending applicants, in practice with this physician.

- 1) If the total exceeds 120 scheduled weekly practice hours, review the rules for limits on CRNP/CNM/PA personnel with one physician:  
ABN Administrative Code Chapter 610-X-5-.03 & .04 for CRNP, 610-X-5-.14 & .15 for CNM.
- 2) The physician is required to notify the Alabama Board of Medical Examiners within in five (5) business days of the commencement or termination of collaborative practice. There is no fee to report Termination of Collaborative Practice. Send the **Physician's Notice of Commencement or Termination in Collaborative Practice to the Board of Medical Examiners.**

- C. **Collaborative Practice Plan.** (Page 2) **Refer to ABN Administrative Code** Chapter 610-X-5-.08 Requirements for Collaborative Practice by Physicians and Certified Registered Nurse Practitioners and 610-X-5-.19 Requirements for Collaborative Practice by Physicians and Certified Nurse Midwives

Specify the scheduled hours per week for the CRNP / CNM, for collaboration with the physician, and the plan for practice in remote sites, if any. Outline the plan for physician availability and emergency medical intervention.

Physicians may implement a written policy, as a part of the Collaborative Practice Protocol, for the delegation of medication administration and injection to unlicensed personnel in a remote site clinics where the Certified Registered Nurse Practitioner / Certified Nurse Midwife provides services. The policy must be submitted as a part of the Collaborative Practice Protocol and maintained on-site in the remote practice site (refer to the statements on the signature page of this collaborative practice application).  
intervention.

- D. **Sites.** List the **physical location/address** for the physician's principal practice site. (Page 3)

**List every collaborative practice site** where the CRNP/CNM applicant will practice under this protocol. Identify hospitals and skilled nursing facilities by checking the box to the right of the facility name. Refer to Alabama Board of Nursing Administrative Code for definitions, collaboration requirements and exemptions to on-site collaboration:

- 1) Definitions: Alabama Board of Nursing Administrative Code Chapter 610-X-2-.05 (1)- (17)
- 2) CRNP: Requirements for Collaborative Practice, rule 610-X-5-.08
- 3) CNM: Requirements for Collaborative Practice, rule 610-X-5-.19

- E. **Protocol:** The standard protocols for CRNP and for CNM are page 4 in the application. Select the protocol that applies to your specialty. If you are applying as a CRNP, discard the page with CNM protocol. If you are applying as a CNM, discard the CRNP protocol.

Additional duties may be requested as provided in Alabama Board of Nursing Administrative Code Chapter 610-X-5-.10 for the CRNP and 610-X-5-.21 for the CNM. List the requested procedure in **section J** of the printed protocol. Attach the proposed protocol for each procedure. Prior to performing the procedure, you must submit documentation of the education and/or certification with supervised clinical practice that qualifies you to perform each function/procedure that you request. Use additional pages as needed; include the name and license number of the CRNP/CNM applicant and the collaborating physician on every page.

**F. Formulary.** (Page5)

- 1) The Standard Formulary for CRNP and CNM is listed by drug classification, items 1-24.
- 2) **Identify specific restrictions on individual drug classifications by checking the box** in the Formulary of this CRNP/CNM applicant. State the restriction opposite the classification.
- 3) **Drug classifications with Board-designated restrictions** (items 26 – 30 on the formulary page):  
If requesting prescribing authority for any of these classifications, attach a description of the patient population, disease process or other circumstances for CRNP/CNM prescribing in drug classifications. Specify the restrictions within the protocol for this CRNP/CNM applicant. The CRNP/CNM and physician must initial each box to confirm the request for the following drugs classifications.
  26. **Antineoplastic agents**
  27. **Heavy metals**
  28. **Gold Compounds**
  29. **Oxytocics for CRNP**
  30. **Radioactive Agents** *If requested, attach a copy of the **physician's current license from the Alabama Department of Public Health for prescribing/dispensing radioactive pharmaceuticals**. Attach the prescribing protocol for the applicant with this physician.*
- 4) For other drug classifications that you think are not within the Standard Formulary classifications, attach a page with your request and the protocol for prescribing in the proposed collaboration.

**G. Quality Monitoring.** (Page 6) Refer to the Alabama Board of Nursing Administrative Code Chapter 610-X-5-.10 (4) for CRNP and 610-x-5-.21 (4) for CNM.

- 1) Specify a plan for quality assurance management with established patient outcome indicators for evaluation of the clinical practice of the certified registered nurse practitioner. Quality assurance monitoring may be performed by designated personnel, with final results presented to the physician and certified registered nurse practitioner for review.
- 2) Include review of no less than ten percent (10%) of medical records in addition to all adverse outcomes.
- 3) Documentation of quality assurance review shall be readily retrievable, identify records that were selected for review, include a summary of findings, conclusions, and, if indicated, recommendations for change.

**H. Signatures.** (Page 7) Original signatures are required. Do not submit photocopy or fax copy of signature.

**I. Covering physicians.** (Page 8) A back-up physician who has been approved by the Board of Medical Examiners specifically for this collaborative practice may provide medical coverage during the temporary absence of the collaborating physician. Covering physician status lapses immediately when the collaborating physician or CRNP/CNM terminates the collaborative practice agreement. If there is no approved covering physician, the CRNP/CNM is not authorized for practice when the collaborating physician is unavailable. Refer to Definitions for "Readily Available" and "Direct Medical Intervention."

For more information, refer to the website of the Alabama Board of Nursing [www.abn.alabama.gov](http://www.abn.alabama.gov)

PHONE: 334-242-4060 or TOLL FREE: 1-800-656-5318  
or the Alabama Board of Medical Examiners [www.albme.org](http://www.albme.org) PHONE: 334-242-4116



# Alabama Board of Nursing

## Add or Change Collaborative Practice CRNP or CNM

Check (✓) the specialty for this application.

CRNP \$50

CNM \$50

Date Received \_\_\_\_\_

Mailing address:  
P. O. BOX 303900  
Montgomery AL 36130-3900

Physical address:  
770 Washington Ave, Suite 250  
Montgomery AL 36104-3816

PHONE: 334-242-4060 TOLL FREE: 1-800-656-5318

For more information, refer to our website at [www.abn.state.al.us](http://www.abn.state.al.us)

Send the signed original application, \$50 fee and supporting documents to the Alabama Board of Nursing

LEGAL NAME

\_\_\_\_\_  
Last First Middle Maiden

LIST ANY PREVIOUSLY USED NAMES / ALIASES \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ ALABAMA RN LICENSE NUMBER \_\_\_\_\_

PERMANENT STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DAYTIME PHONE \_\_\_\_\_ FAX \_\_\_\_\_

OTHER PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

### CURRENT CERTIFICATION FOR ADVANCED PRACTICE NURSING :

CERTIFYING ORGANIZATION	SPECIALTY	START AND EXPIRE DATES

Check the items that apply to this application. There is no fee to report a termination of collaborative practice.

1.  Add a new collaborating physician: Name: \_\_\_\_\_

2.  Change my currently approved collaboration
- Add a specialty certification and scope of practice
  - Add practice site or a site away from the collaborating physician.
  - Add duties or skilled procedures to protocol
  - Change formulary

3. What is the status of previously approved collaborations?

Continue    Modify    Terminate: Specify Date    Physician Name and License Number

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> o	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION!**

**AFFIDAVIT FOR AFFIRMATION OF ELIGIBILITY FOR ADVANCED PRACTICE NURSING**

I affirm that the information recorded on this application concerning any item contained herein is true and correct. I understand that I may be required to submit documentation to support my affirmation. I further understand that any false statement is in violation of the Code of Alabama and the Board of Nursing Administrative Code and constitutes cause for disciplinary action.

\_\_\_\_\_  
(Signature of Applicant) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

CRNP/CNM Name and RN License Number \_\_\_\_\_

**Section A. APPLICANT'S EMPLOYER FOR THIS COLLABORATION:**

Employer Name: \_\_\_\_\_  
 Address, City, State, ZIP \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

**Section B. PHYSICIAN INFORMATION. Alabama Board of Medical Examiners determines physician qualification for the collaborating physician.**

1. Collaborating Physician: \_\_\_\_\_  
Print Name As Shown On Physician's Medical License MD/DO License Number

2. Physician's **Mailing** Address \_\_\_\_\_

3. Physician's Telephone Number: \_\_\_\_\_ Physician's Email Address: \_\_\_\_\_

4. Type of Practice: \_\_\_\_\_

5. Medical Specialty of Collaborating Physician: \_\_\_\_\_

6. Is Physician Board Eligible or Certified?  **Yes**  **No** Certificate Number: \_\_\_\_\_

**LIMIT ON CRNPs/CNMs/PAs PER PHYSICIAN.**

List the names, license numbers, and total scheduled hours per week for all CRNPs/CNMs/PAs, **including all other pending applicants**, who will be in collaborative practice with this collaborating physician. The physician is limited to 120 scheduled hrs/week with all CRNP, CNM, and PA personnel. The total does not apply to Covering (back-up) for other collaborating physicians.

Name	License Number	Maximum Hours Scheduled per week in Collaboration with this Physician
<b>TOTAL HOURS =</b>		

**Section C. COLLABORATIVE PRACTICE**

1. Anticipated starting date for this collaborative practice: \_\_\_\_\_

2. Total hours per week will CRNP/CNM applicant will be routinely scheduled in this collaborative practice, including all sites, excluding time on call. TOTAL WEEKLY HOURS: \_\_\_\_\_

3. Will the CRNP / CNM practice in the physician's principal practice site?  Yes, routinely  No  
 Yes, rarely or as needed  
 List the physician's site in Section D PRACTICE SITES

4. Minimum number of hours per week the collaborating physician or an authorized covering physician will be present with this CRNP/CNM in a practice site listed in this protocol, cumulative per week for all sites. MINIMUM With Physician: \_\_\_\_\_

5. How is the collaborating or covering physician available for consultation and/or referral when not present on-site with the CRNP/CNM?

6. How will patients receive medical intervention during hours when the site is closed?

7. How will patients receive medical intervention in emergency situations?

**Section D. PRACTICE SITES**

Duplicate this page as needed. Include the CRNP/CNM and physician license numbers on attachments.

<b>Physician's Principal Practice Site</b>	
Physical Address	
City ZIP	
Telephone	

List <b>every collaborative practice site</b> where the CRNP/CNM applicant will practice under this protocol. Identify acute care hospitals, licensed skilled nursing facilities, assisted living facilities and special care assisted living facilities by checking the box in the respective column.		Hospital or SNF	ALF or SCALF
1. Will the CRNP/CNM practice in the Physician's Principal Practice Site:	<input type="checkbox"/> Yes, routinely <input type="checkbox"/> Yes, rarely or as needed <input type="checkbox"/> No		
Practice Site Name	2.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	3.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	4.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	5.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	6.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	7.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	8.		
Physical Address			
City ZIP			
Telephone			

**Section E:**

**CERTIFIED REGISTERED NURSE PRACTITIONER PROTOCOL**

1. The certified nurse practitioner (CRNP) may work in any setting consistent with the collaborating physician's areas of practice and function within the CRNP's specialty scope of practice. The CRNP's scope of practice shall be defined as those functions and procedures for which the CRNP is qualified by formal education, clinical training, area of certification and experience to perform.

2. The following represents the functions which may be performed by the CRNP:

A. Perform complete, detailed and accurate health histories, review patient records, develop comprehensive medical and nursing status reports, and order laboratory, radiological and diagnostic studies appropriate for complaint, age, race, sex and physical condition of the patient.

B. Perform comprehensive physical examinations and assessments, including bimanual pelvic examinations. Record pertinent data in appropriate medical records.

C. Formulate medical and nursing diagnoses and institute therapy or referrals of patients to the appropriate health care facilities, agencies, other resources of the community or physician.

D. Plan and initiate a therapeutic regimen which includes ordering legend drugs, medical devices, nutrition and supportive services.

E. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning, allergic reactions and emergency obstetric delivery.

F. Arrange inpatient admissions and discharges at the direction of the collaborating physician; write admission orders for inpatients as directed by the physician and subsequent orders in accordance with established protocols and institutional policies; issue diagnostic and therapeutic orders including orders for legend drugs; perform rounds and record appropriate patient progress notes; compile detailed narrative and case summaries; complete forms pertinent to patients' medical records.

G. Interpret and analyze patient data to determine patient status, patient management and treatment.

H. Provide instructions and guidance regarding health care and health care promotion to patients/family/ significant others.

I. In addition to functions/procedures within the scope of RN practice, perform or assist with laboratory procedures and technical procedures, which include but are not limited to the following:

- |   |   |
|---|---|
| Wet mount microscopy and interpretation of vaginal swab     | Debridement of wounds   |
| Microscopic urinalysis                                      | Aspiration, incision and drainage of superficial lesions                        |
| Biopsy of superficial lesions                               | Foreign body removal  |
| Suturing of superficial lacerations                         | Initial x-ray interpretation, with subsequent required physician interpretation |
| Management and removal of arterial and central venous lines | Cast application/removal  |

**J. Additional duties requested for the CRNP (i.e., diagnostic or therapeutic procedures requiring additional training) as provided in ABN Administrative Code Chapter 610-X-5-10 (3). See directions with this form for documentation of instruction and practice.**

Function	What Documentation Is Attached?

**Section E:  
CERTIFIED NURSE MIDWIFE PROTOCOL**

1. The certified nurse Midwife (CNM) may work in any setting consistent with the collaborating physician's areas of practice and function within the CNM's specialty scope of practice. The CNM's scope of practice shall be defined as those functions and procedures for which the CNM is qualified by formal education, clinical training, area of certification and experience to perform.
  
2. The following represents the functions which may be performed by the CNM:
  - A. Perform complete, detailed and accurate health histories, review patient records, develop comprehensive medical and nursing status reports, and order laboratory, radiological and diagnostic studies appropriate for complaint, age, race, sex and physical condition of the patient.
  
  - B. Perform comprehensive physical examinations and assessments and record pertinent data in appropriate medical records.
  
  - C. Formulate medical and nursing diagnoses and institute therapy or referrals of patients to the appropriate health care facilities, agencies, other resources of the community or physician.
  
  - D. Plan and initiate a therapeutic regimen which includes ordering legend drugs, medical devices, nutrition and supportive services.
  
  - E. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning, allergic reactions and emergency obstetric delivery.
  
  - F. Arrange inpatient admissions and discharges in accordance with established guidelines/standards developed within the collaborative practice; write admission orders for inpatients as directed by the physician and subsequent orders in accordance with established protocols and institutional policies; issue diagnostic and therapeutic orders including orders for legend drugs; perform rounds and record appropriate patient progress notes; compile detailed narrative and case summaries; complete forms pertinent to patients' medical records.
  
  - G. Interpret and analyze patient data to determine patient status, patient management and treatment.
  
  - H. Provide instructions and guidance regarding health care and health care promotion to patients/family/ significant others.
  
  - I. In addition to functions/procedures within the scope of RN practice, perform or assist with laboratory procedures and technical procedures, which include but are not limited to the following:
 

Bimanual pelvic examination	Amniotomy
Wet mount microscopy and interpretation	Amnioinfusion
Microscopic urinalysis	Local and pudendal anesthesia
Insertion of intrauterine devices	Spontaneous vaginal delivery
Fit diaphragm, cervical cap	Episiotomy
Simple skin biopsy/punch biopsy	Episiotomy and laceration repair
Incision and drainage of superficial lesions	Management of abnormal birth events until physician arrives
	Manual removal of placenta
	Uterine exploration
  
  - J. **Additional duties requested for the CNM (i.e., diagnostic or therapeutic procedures requiring additional training) as provided in ABN Administrative Code Chapter 610-X-5-.21 (3). See directions with this form for documentation of instruction and practice.**

Function	What Documentation Is Attached?

**Section F. Standard Formulary of Legend Drug Classifications for CRNP and CNM**

**Prescriptive authority for CRNP and CNM does not include controlled substances in any schedule.**

Authorized categories of drugs should reflect the needs of the medical practice in which the CRNP/CNM is working. All written prescriptions must adhere to the standard, recommended doses of legend drugs, as identified in the Physicians' Desk Reference or the product information insert, not to exceed the recommended treatment regimen periods.

**If a drug classification is specifically restricted in this collaborative practice protocol, check (✓) the box and state restrictions in area provided or on additional pages as needed for legibility.**

Medication	<u><b>If restricted</b></u> , check the box and <b>state the restrictions</b>
1. Antihistamines and Decongestants	<input type="checkbox"/> _____
2. Analgesics and Antipyretics	<input type="checkbox"/> _____
3. Blood Derivatives	<input type="checkbox"/> _____
4. Coagulation Agents	<input type="checkbox"/> _____
5. Central Nervous System Agents	<input type="checkbox"/> _____
6. Agents of Electrolytic, Caloric and Water Balance	<input type="checkbox"/> _____
7. Expectorants and Cough Preparation	<input type="checkbox"/> _____
8. Gastrointestinal Drugs	<input type="checkbox"/> _____
9. Local Anesthetics	<input type="checkbox"/> _____
10. Pulmonary Drugs	<input type="checkbox"/> _____
11. Spasmolytics	<input type="checkbox"/> _____
12. Vitamins	<input type="checkbox"/> _____
13. Anti-Infective Agents	<input type="checkbox"/> _____
14. Autonomic Drugs	<input type="checkbox"/> _____
15. Blood Formation	<input type="checkbox"/> _____
16. Cardiovascular Drugs	<input type="checkbox"/> _____
17. Diagnostic Agents	<input type="checkbox"/> _____
18. Enzymes	<input type="checkbox"/> _____
19. Ophthalmic Drugs	<input type="checkbox"/> _____
20. Anti-Inflammatory Drugs	<input type="checkbox"/> _____
21. Hormone and Synthetic Drugs	<input type="checkbox"/> _____
22. Birth Control Drugs and Devices	<input type="checkbox"/> _____
23. Serums, Toxoids, Vaccines	<input type="checkbox"/> _____
24. Prosthetics/Orthotics	<input type="checkbox"/> _____
25. <b>OXYTOCICS for CNM:</b> <i>may be prescribed according to protocols for management of post-partum bleeding, and in concurrent consultation with the physician for augmentation of labor.</i>	

**NOTE: Refer to instruction page regarding items 26-30. If requested and approved for this applicant, the following drugs may be prescribed within the limitations defined below by the Alabama Board of Nursing and the Alabama Board of Medical Examiners. Initial each classification that you are requesting.**

	CRNP/CNM	MD/ DO
26. <b>ANTINEOPLASTIC AGENTS:</b> <i>Initial dose must be prescribed by a physician, with authorization to prescribe continuing maintenance doses according to written protocol or direct order of the physician.</i>		
27. <b>HEAVY METALS:</b> <i>Initial dose must be prescribed by a physician with authorization from the collaborating physician to prescribe continued maintenance dosages.</i>		
28. <b>GOLD COMPOUNDS:</b> <i>Initial dose must be prescribed by a physician with authorization from the collaborating physician to prescribe continued maintenance dosages.</i>		
29. <b>OXYTOCICS for CRNP</b> – <i>may be prescribed only in consultation with the physician.</i>		
30. <b>RADIOACTIVE AGENTS:</b> <i>If requested, attach a copy of the <b>physician's current license from the Alabama Department of Public Health for prescribing/dispensing radioactive pharmaceuticals.</b> Attach the prescribing protocol for the applicant with this physician.</i>		
31. <b>Other: See instruction page.</b>		

**Section G: QUALITY ASSURANCE PLAN**

**ABME Rule 540-X-8.01 and ABN Rule 610-X-2.05**

(12) Medical Oversight: Concurrent and on-going collaboration between a physician and a CRNP or CNM and documentation of time together in a practice site; may include but is not limited to direct consultation and patient care, discussion of disease processes and medical care, review of patient records, protocols and outcome indicators, and other activities to promote positive patient outcomes.

(13) Quality Assurance: Documented evaluation of the clinical practice of the certified registered nurse practitioner or certified nurse midwife against established patient outcome indicators, using a specified percentage or selected sample of patient records, with a summary of findings, conclusions, and, if indicated, recommendations for change.

**ABME Rule 540-X-8.08 (9) (g) & ABN Rule 610-X-5.08 (9) for CRNP**

**ABME Rule 540-X-8.22 (9) (g) & ABN Rule 610-X-5.19 (9) (g) for CNM**

(g) Specify a plan for quality assurance management with established patient outcome indicators for evaluation of the clinical practice of the certified registered nurse practitioner/certified nurse midwife and include review of no less than ten percent (10%) of medical records plus all adverse outcomes. Documentation of quality assurance review shall be readily retrievable, identify records that were selected for review, include a summary of findings, conclusions, and, if indicated, recommendations for change. Quality assurance monitoring may be performed by designated personnel, with final results presented to the physician and certified registered nurse practitioner for review.

**Check at least one item in the three components of Quality Assurance plan listed below.**

**Review and sign the acknowledgements on the Collaboration Agreement page.**

A. WHO WILL REVIEW MEDICAL RECORDS?

- Agency/facility committee
- Certified registered nurse practitioner/collaborating physician jointly
- Collaborating physician
- Quality Assurance professional
- Any of those listed above
- Other (specify): \_\_\_\_\_

B. TIME FRAME FOR REVIEW

- Weekly
- Monthly
- Other (specify): \_\_\_\_\_

C. SELECTION OF RECORDS FOR REVIEW

Select records from patients treated by the CRNP/CNM

**Required:**

**100% of records for patients with adverse outcomes**

**10% all patient records within the designated calendar interval.**

- Other. Describe criteria for selecting records to be reviewed.

CRNP / CNM Name and License

Physician Name and License

**COLLABORATION AGREEMENT FOR CRNP/CNM AND PHYSICIAN**

The application requires the signatures of the CRNP/CNM applicant and collaborating physician.

Review each statement. **Sign your name below.**

The collaborating physician may authorize non-licensed employees who serve as medical assistants in approved collaborative practice sites to perform injections on patients.

**PRESCRIBING AUTHORITY:**

I request authorization for prescriptive privileges for CRNP and CNM named in this document and collaboration protocol using the Standard Formulary of Legend Drug Classifications. Specified restrictions on drug classifications for our protocol, if any, are noted on the enclosed Standard Formulary.

I am aware the Alabama Controlled Substances list includes some medications that are not controlled by the Drug Enforcement Administration, and are not marked by the manufacturer with the symbol to indicate the control schedule. I am familiar with the Controlled Substances list posted on the website of the Alabama Department of Public Health [www.adph.org](http://www.adph.org)

I acknowledge the CRNP/CNM named in this document **is not authorized to prescribe controlled drugs in any schedule.**

I acknowledge the collaborating physician and CRNP/CNM shall be held responsible for any act or omission of the CRNP/CNM arising out of the CRNP's/CNM's prescribing to patients.

**QUALITY ASSURANCE:**

I have reviewed the regulations pertaining to Quality Assurance and understand my responsibilities for executing the Quality Assurance plan in this document.

**PROTOCOL FOR COLLABORATION: We hereby certify under penalty of law of the State of Alabama that the foregoing information in this application is correct to the best of our knowledge and belief. We certify that we have reviewed the current rules and regulations of the state of Alabama pertaining to CRNPs/CNMs and understand our responsibilities. We understand that we are jointly and individually responsible for complying with the rules and regulations pertaining to CRNPs/CNMs and the collaborative practice of CRNPs/CNMs with physicians.**

\_\_\_\_\_  
Print Collaborating Physician's Name

\_\_\_\_\_  
Signature of Collaborating Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**COVERING PHYSICIAN AGREEMENT:**

- Submit signed original forms to the Alabama Board of Nursing with the collaborative practice application.
- Do not submit photocopy or fax copy of signatures.
- Additional covering physician signatures may be submitted using the **Application to Add or Delete Covering (Back-Up) Physician** (no additional fee). Print the blank form at [www.abn.state.al.us](http://www.abn.state.al.us) > Applications.
- A covering physician who is pre-approved by the State Board of Medical Examiners and is familiar with the rules for collaborative practice may provide medical coverage (back-up) in the event the collaborating physician is not readily available.
- This covering physician agreement applies only to the collaborating physician named in this application and listed at the top of this page.
- The covering physician agreement lapses immediately when the CRNP/CNM or collaborating physician terminates the collaborative practice agreement.

**To: Alabama Board of Nursing  
Alabama Board of Medical Examiners**

As a covering (back-up) physician providing guidance and direction for the CRNP/CNM applicant named above:

- I hereby affirm that I am familiar with the current regulations regarding  CRNPs  CNMs, and the collaborative practice protocol filed by the primary collaborating physician.
- I approved the drug type, dosage, quantity, and number of refills of legend drugs which the CRNP/CNM is authorized to prescribe in the formulary included with the protocol.
- I will be accountable for adequately providing oversight of the medical care rendered pursuant to the CRNP/CNM protocol during the temporary absence of the primary collaborating physician.

Provide the **mailing address for the covering physician(s)** if different from the collaborating physician's mailing address.

Signature of covering (back-up) physician	Date Signed	Name of the covering physician. (Type or print legibly.)	License Number

**Request for Exemption  
from Collaborative Practice with  
a Physician Licensed To Practice Medicine or Osteopathy in Alabama**

	YES	NO
I request exemption from collaborative practice with a physician licensed to practice medicine or osteopathy in Alabama.	<input type="checkbox"/>	<input type="checkbox"/>

**FACULTY**

I am employed as faculty in a nurse practitioner education program.	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------

I have requested written confirmation of faculty status from the dean/ program director of the nurse practitioner education program:	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

Name of School \_\_\_\_\_

**EMPLOYED BY U S GOVERNMENT**

I am employed by the United States government, practicing a federal facility with a physician is who is licensed in another state or US territory.	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

Name of Facility/Agency: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician License Number: \_\_\_\_\_

Name of State or US Territorial Licensing Board: _____	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

Request the Licensing Board to send official verification of the physician's license to the Alabama Board of Nursing, P. O. BOX 303900, Montgomery AL 36130 or [abn@abn.state.al.us](mailto:abn@abn.state.al.us)

Print CRNP or CNM Applicant Name	License Number
----------------------------------	----------------

Signature of Applicant	Date
------------------------	------



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 fee to the Alabama Board of Medical Examiners.

Instructions for Commencement:

- 1. Fill out form completely. Include license numbers from both CRNP/CNM and the physician
2. Include the date the CRNP/CNM began providing services
3. Include the fee of \$100.00 for the Collaborative Practice
4. Make checks payable to: Alabama Board of Medical Examiners

SEND THIS PAGE ONLY TO: Alabama Board of Medical Examiners
Attn: Cheryl Thomas, RN, MSM, or Patricia Enfinger, RN
Collaborative Practice Inspectors

(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. CRNP/CNM began providing services under the Collaborative Practice Agreement

This is to certify that I, the undersigned physician, have read and understand the Alabama Board of Medical Examiners Rules, Chapter 540-X-8, Advanced Practice Nursing: Collaborative Practice. I also understand that failure to adhere to the rules may result in an action against my license.

6. PHYSICIAN'S SIGNATURE: DATE:

(Original Signature Only)

Important Note: In the event you must terminate this Collaborative Practice it is the Physicians responsibility to notify the Alabama Board of Medical Examiners in writing [(Rule 540-X-8-.04 (4) (b))] within five (5) business days of this termination. Termination form may be found on our website at www.albme.org under Collaborative Practice Information.