Cover Sheet for Advanced Practice Nurse Collaborative Agreement

1. Name of Facility: ________________________________________________________________

2. Name of Advanced Practice Nurse: _________________________________________________

3. Indiana License Number for RN and Certification for Advanced Practice Nurse (RN/APN/CSR):
   _____________________________________________________ ________________________________

4. Type of Request (Check One):
   ______ New Collaborative Agreement  ______ Additional Collaborative Agreement

5. For any Collaborative Agreements, are the following included:
   ______ Name, business address, home address, zip codes, telephone numbers and license numbers for APN and physician
   ______ Coverage Clause Included
   ______ Review Clause Included

6. For changes in Collaborative Agreements, please place a check next to the type(s) and include a detailed cover letter on letterhead which indicates exactly which physicians you are adding/deleting/keeping, which locations you are adding/deleting/keeping and the date the changes should take effect:
   ______ Add Physician to existing Agreement with no other changes
   ______ Delete Physician from existing Agreement with no other changes
   ______ Change Physicians on existing Agreement with no other changes
   ______ Add locations to existing Agreement with no other changes
   ______ Delete locations to existing Agreement with no other changes
   ______ Change location to existing Agreement
   ______ Cancel Current CSR
   ______ Request to Update CSR

**Please Note: If you do not have a CSR and you intend to administer and dispense controlled substances, you must fill out the CSR application, pay the fee and complete the requirements including but not limited to the criminal background check.**