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). Please indicate if application is pending:

   ________________________________________________________________

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 over 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.**