Collaboration Agreement
Physician Assistant / Patient Care Team Physician

Please Note:

******The Board's Collaboration Agreement Sample may not address each particular employment arrangement between a physician assistant and patient care team physicians.******

*****The Board expects that the executed Collaboration Agreement accurately reflects the physician assistant's specific participation with the patient care team physicians.*****

Important Information

1. **Use of this board-provided Collaboration Agreement sample form is not required.** Physician Assistants, in collaboration with one or more Patient Care Team Physicians, may create their own Collaboration Agreement provided that the “self-created” Collaboration Agreement contains the requirements of Sections §15-302, §15-302.1, & §15-302.2 of the Health Occupations Article and is immediately available upon request by the Board.

2. **Execute a Collaboration Agreement between a Physician Assistant and one or more Patient Care Team Physicians.** A Collaboration Agreement must include and list one Physician Assistant and one or more Patient Care Team Physicians. If multiple Patient Care Team Physicians are listed, the Patient Care Team Physicians may be of different practice specialties). A Physician Assistant may only practice within the practice specialties of the Patient Care Team physician(s) listed on the collaboration agreement.

3. **The Physician Assistant is required to notify the board of the executed collaboration agreement before practicing as a Physician Assistant under this Collaboration Agreement.** The Board of Physicians (the Board) does not require a copy of the Collaboration Agreement to be submitted to the Board or be approved by the Board. The Physician Assistant must notify the Board of the executed Collaboration Agreement between the Physician Assistant and one or more Patient Care Team Physicians.

4. **Maintain a copy of the executed collaboration agreement on file at the Physician Assistant's primary place of practice.** Collaboration Agreements shall be kept on file at the practice setting, either hardcopy or electronically, and made immediately available to the Board upon request.

ADVANCED DUTIES:

Information on Advanced Duties and the Collaboration Agreement Advanced Duty Addendum, may be found on the Board’s website:

https://www.mbp.state.md.us/resource_information/res_pro/resource_practitioner_forms_ah.aspx

Collaboration Agreement
Physician Assistant / Patient Care Team Physician

Instructions

TO BE COMPLETED BY THE PHYSICIAN ASSISTANT:

1. **Physician Assistant Information:** Complete all requested information.
2. **Physician Assistant Collaboration:**
   - **Name of Employer:** Provide the name of the entity that employs the Physician Assistant and the Patient Care Team Physician (s) listed on this Collaboration Agreement. The same entity should employ all listed practitioners.
   - **Address, City, State, & Zip Code:** Complete all requested information.
   - **Employer Contact:** Provide a name and telephone number for a contact at the employer's facility.
   - **The location where the collaboration agreement is on file and immediately available upon request of the Board:** This location should be the Physician Assistants' primary place of business.
   - **Description of Physician Assistant Qualifications:** Provide any applicable information regarding the Physician assistant's education, training, and experience.
3. **Telehealth:** Indicate whether the Physician Assistant will be practicing medicine via telehealth.
4. **Prescriptive Authority:** Check the applicable box indicating the Physician Assistant's request to be delegated prescriptive authority by a Patient Care Team Physician.
5. **Dispensing Authority:** Check the applicable box indicating the Physician Assistant's request to be delegated dispensing authority by a Patient Care Team Physician *with an active dispensing permit* issued by the Board.
6. **Delegation by a Physician Assistant:** Check the applicable box to attest to whether or not the Physician Assistant will be delegating medical acts to personnel, whether licensed or unlicensed, as authorized under § 14–306 of the Health Occupations Article.
7. **Advanced Duties:** Check the applicable box to attest to whether the Physician Assistant will be performing Advanced Duties. For additional information, see the Board's website.
8. **Physician Assistant Attestation:** The Physician Assistant must attest to the provided statement.
9. **Physician Assistant Affirmation**: Your signature affirms that you personally completed the collaboration agreement and understand its contents.

Instructions (Continued)

TO BE COMPLETED BY THE PATIENT CARE TEAM PHYSICIAN:

10. **Patient Care Team Physician Information**: Complete all requested information.

11. **Patient Care Team Physician Collaboration:**

    - **Name of Employer:** Provide the name of the entity that employs the Physician Assistant and the Patient Care Team Physician (s) listed on this Collaboration Agreement. The same entity should employ all listed practitioners.
    - **Patient Care Team Physician Practice Specialties:** To be completed by a Physician.
    - **Description of Patient Care Team Physician Qualifications:** Provide any applicable information regarding the physician's education, training, and experience.
    - **Limitations on Physician Assistant's Practice:** A collaboration agreement may include provisions limiting the physician assistant's scope of practice, specifying office procedures, or otherwise detailing the practice of the physician assistant as agreed by the physician or group of physicians and the physician assistant.

12. **Delegation of Prescriptive Authority:** Check the applicable box indicating the Patient Care Team Physicians delegation of prescriptive authority to a Physician Assistant.

13. **Delegation of Dispensing Authority:** Check the applicable box indicating the Patient Care Team Physicians delegation of dispensing authority to a Physician Assistant. If a delegating dispensing authority to the Physician Assistant, provide the Patient Care Team Physician's CDS registration number and expiration date issued by the Office of Controlled Substances Administration (OCSA) and the Patient Care Team Physician's dispensing permit number and expiration date issued by the Maryland Board of Physicians.

14. **Patient Care Team Physician Affirmation**: Your signature affirms that you personally completed the collaboration agreement and understand its contents.

REQUIRED:

Once the Physician Assistant and one or more Patient Care Team Physicians execute a Collaboration Agreement:

- **The Physician Assistant is required to notify the board of the executed collaboration agreement before practicing as a Physician Assistant under this Collaboration Agreement.**

  &

- **The Physician Assistant is required to maintain a copy of the executed collaboration agreement on file at the Physician Assistant's primary place of practice, either in hardcopy or electronically, and make it immediately available to the Board upon request.**

Collaboration Agreement
Physician Assistant / Patient Care Team Physician

1. Physician Assistant Information.

Last Name (Suffix, Jr., III):	First Name:
Middle/Maiden Name:	Maryland License #:
Email:	Telephone #:

2. Physician Assistant Collaboration.

Name of Employer:____

Address:____

City:______________________ **State:**______________ **Zip Code:**__________

Employer Contact:__________________________ **Phone:**____________________

The location where the collaboration agreement is on file and immediately available upon request of the Board:

Address:____

City:______________________ **State:**______________ **Zip Code:**__________

Practice Settings:

- ☐ Ambulatory Surgical Facility
- ☐ Detention Center / Correctional Facility
- ☐ HMO
- ☐ Hospital
- ☐ Nursing Home
- ☐ Outpatient Clinic
- ☐ Public Health Facility
- ☐ Private Practice
- ☐ Urgent Care Center
- ☐ Other:______________

Description of Physician Assistant Qualifications:____

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3. Telehealth.

Will you be practicing telehealth?

- ☐ **I will not be** practicing Telehealth.
- ☐ Yes, and **I will be** physically located in Maryland.
- ☐ Yes, and **I will not be** physically located in Maryland.

4. Prescriptive Authority.

☐ **I ATTEST THAT:**

1. All prescribing activities by me, the physician assistant, will comply with all federal and State laws and regulations governing the prescribing of medications, including controlled dangerous substances.
2. All medical charts or records will contain a notation of any prescriptions written by me, the physician assistant, in accordance with Health Occupations Article, §15-302.2.
3. All prescriptions written by me, the physician assistant, will include my name, business address, and business telephone number, legibly written or printed.
4. I have passed the physician assistant national certification exam administered by the National Commission on the Certification of Physician Assistants (NCCPA) within the previous 2 years or have successfully completed 8 category 1 hours of pharmacology education within the previous 2 years.
5. I have a bachelor's degree or its equivalent or have successfully completed 2 years of work experience as a physician assistant.

NOTE*: PAs must obtain registrations with the Maryland Office of Controlled Substances Administration and the Drug Enforcement Administration before prescribing or dispensing controlled dangerous substances.*

OR

☐ **I AM NOT REQUESTING PRESCRIPTIVE AUTHORITY.**

5. Dispensing Authority.

☐ **I ATTEST THAT (must be requesting prescriptive authority):**

1. All dispensing activities by me, the physician assistant, will comply with all federal and State laws and regulations governing the dispensing of medications, including controlled dangerous substances.
2. All medical charts or records will contain a notation of any prescriptions dispensed by me, the physician assistant, in accordance with Health Occupations Article, §15-302.2.
3. All prescriptions dispensed by me, the physician assistant, will include my name, and the patient care team physician's name, business address, and business telephone number, legibly written or printed.

OR

☐ **I AM NOT REQUESTING DISPENSING AUTHORITY.**

6. Delegation of Medical Acts by a Physician Assistant.

☐ **I ATTEST THAT** I, the physician assistant, have at least 7,000 hours of clinical practice experience and will be delegating medical acts to personnel, whether licensed or unlicensed, as authorized under § 14–306 of the Health Occupations Article.

OR

☐ **I ATTEST THAT** I, the physician assistant, am **not delegating** medical acts to licensed or unlicensed personnel.

7. Advanced Duties.

☐ **I ATTEST THAT** I, the physician assistant, **will not** be performing advanced duties as part of this collaboration agreement.

OR

☐ **I ATTEST THAT** I, the physician assistant, **will** be performing advanced duties as part of this collaboration agreement and will request and be granted Board approval before performing any advanced duty according to § 15–302.1 of the Health Occupations Article.

OR

☐ **I ATTEST THAT I,** the physician assistant, will be performing advanced duties as part of this collaboration agreement and meet at least one of the following exceptions. Therefore, I do not require Board approval to perform advanced duties.

(Must check at least one box below)

- ☐ I will be practicing as a physician assistant in an exempt location as defined in § 15–302.1 (A-B) of the Health Occupations Article.
- ☐ The Board has previously approved me to perform the advanced duty in collaboration with a patient care team physician according to § 15–302.1 (E) (1) of the Health Occupations Article.
- ☐ I have completed at least 7,000 hours of clinical practice experience according to § 15–302.1 (E) (2) of the Health Occupations Article.

8. Attestations by the Physician Assistant.

☐ **I ATTEST THAT** all medical acts that I perform, as a physician assistant, shall be:

A. Appropriate to my education, training, and experience as a physician assistant;

B. Customary to the practice of a patient care team physician listed on the collaboration agreement; and

C. Performed in a manner consistent with this collaboration agreement.

9. Affirmation.

I SOLEMNLY AFFIRM, under the penalties of perjury, that the contents of the foregoing document are true to the best of my knowledge, information, and belief.

Physician Assistant Printed Name:______________________________

Physician Assistant Signature:________________________ ***Date:***____________

Collaboration Agreement
Physician Assistant / Patient Care Team Physician

10. Patient Care Team Physician.

Last Name (Suffix, Jr., III):	First Name:
Middle/Maiden Name:	Maryland License #:
Email:	Telephone #:

11. Patient Care Team Physician Collaboration.

Name of Employer:____

Patient Care Team Physician Practice Specialties:

- ☐ Addiction Medicine
- ☐ Adult Critical Care
- ☐ Allergy / Immunology
- ☐ Anesthesiology
- ☐ Cardiology
- ☐ Cardiovascular Surgery
- ☐ Dermatology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Family Medicine
- ☐ Geriatrics
- ☐ Gastroenterology & Hepatology
- ☐ Hospital Medicine
- ☐ Internal Medicine
- ☐ Infectious Disease
- ☐ Neonatology
- ☐ OB/GYN
- ☐ Occupational Medicine
- ☐ Nephrology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Oncology Ophthalmology
- ☐ Orthopedic
- ☐ Orthopedic Surgery
- ☐ Otolaryngology (ENT)
- ☐ Pain Management
- ☐ Pathology
- ☐ Pediatrics
- ☐ Pediatric Critical Care
- ☐ Pediatric Surgery
- ☐ Plastic Surgery
- ☐ Psychiatry
- ☐ Radiation Oncology
- ☐ Rheumatology
- ☐ Public Health
- ☐ Preventative Medicine, General
- ☐ Physical Medicine & Rehabilitation
- ☐ Pulmonology
- ☐ Radiology
- ☐ Sleep Technology
- ☐ Surgery, General
- ☐ Transplant Surgery
- ☐ Thoracic
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Other:____________________

Patient Care Team Physician Qualifications:____________________________________

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Limitations on Physician Assistant's Practice (if applicable):____________________________

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12. Prescriptive Authority.

☐ **I ATTEST THAT:**

1. All prescribing activities by the physician assistant will comply with all federal and State laws and regulations governing the prescribing of medications, including controlled dangerous substances.
2. All medical charts or records will contain a notation of any prescriptions written by the physician assistant in accordance with Health Occupations Article §15-302.2.
3. All prescriptions written by the physician assistant will include the physician assistant's name, business address, and business telephone number, legibly written or printed.

OR

☐ **I AM NOT DELEGATING PRESCRIPTIVE AUTHORITY.**

13. Dispensing Authority.

☐ **I ATTEST THAT (must be delegating prescriptive authority):**

1. All dispensing activities by the physician assistant will comply with all federal and State laws and regulations governing the dispensing of medications, including controlled dangerous substances.
2. All medical charts or records will contain a notation of any prescriptions dispensed by the physician assistant in accordance with Health Occupations Article §15-302.2.
3. All prescriptions dispensed by the physician assistant will include the physician assistant's name and my name, business address, and business telephone number, legibly written or printed.

Physician CDS Registration Number: ________________________________ ***Expiration Date:*** ____________________

Physician Dispensing Permit Number: ________________________________ ***Expiration Date:*** ____________________

OR

☐ **I AM NOT DELEGATING DISPENSING AUTHORITY.**

14. Affirmation.

I SOLEMNLY AFFIRM, under the penalties of perjury, that the contents of the foregoing document are true to the best of my knowledge, information, and belief.

Patient Care Team Physician Printed Name: ____

Patient Care Team Physician Signature: ________________________________ ***Date:*** ________________