TELEPHONE: (601) 987-3079

FAX: (601) 987-6822

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

Collaboration Information Form

The information on this form must be completed by the collaborative physician on **each** of his/her advanced practice registered nurse(s) (APRN).

Physician Name:__________________________________ **License Number:**________________________

Specialty: _______________________________________ **Date of Birth:**___________________________

SS #: xxx-xx-___________ **Phone Number:**________________________

I am providing this form to the Board in order to : *(please check one)*

____ ***Add*** **an APRN to my collaborative information on file with the Board.**

____ ***Delete*** **an APRN from my collaborative information on file with the Board.**

____ ***Modify*** **an existing APRN on my collaborative practice information on file with the Board.**

Relationship Responsibility: _____ ***Primary*** _____ ***Secondary*** *(please check one)*

Name and Address of your Primary Practice Location:____

____

Your Email Address:____

Backup Physician(s):____

____

Advanced Practice Registered Nurse:____

Specialty:____________________________ **RN Number:**_____________ **Work Status:**

Name and Address of APRN Clinic Location:______________________ _____ ***Full Time***

____ _____ ***Part Time***

APRN Clinic Location Phone Number:____________________________ _____ ***PRN***

I certify that the above information is true and correct to the best of my knowledge.

Physician Signature:__________________________________ **Date:**___________________