FORM TO TERMINATE A COLLABORATIVE PRACTICE AGREEMENT

The Arkansas State Board of Nursing (ASBN) must have a copy of your current Collaborative Practice Agreement (CPA) that identifies your current collaborating physician(s). To terminate your CPA, complete this form and submit through your Nurse Portal.

I, _____ _____, am notifying the Arkansas
(Clearly Print First & Last Name & Title) *(License #)*

State Board of Nursing that I am **terminating** my Collaborative Practice Agreement & Quality Assurance Plan with the following physician(s) to be effective on _____/_____/_____.

_____, MD _____, MD

_____, MD _____, MD

_____, MD _____, MD

_____, MD _____, MD

Name of Practice Site: _____ **Practice Phone #:**_____

Practice Address: _____

_____

☐ I am **not** submitting a new Collaborative Practice Agreement at this time.

OR

☐ I am submitting a **new** Collaborative Practice Agreement, which includes my collaborating physician(s) and Quality Assurance Plan, to be effective on _____/_____/_____.

AND/OR

☐ I have a current Collaborative Practice Agreement with Dr. _____ at _____.
site
Therefore my prescriptive authority will remain active.

I understand that I **cannot** receive or prescribe medications or therapeutic devices unless I have an approved Collaborative Practice Agreement and Quality Assurance Plan on file with ASBN.

_____ _____
(Signature of APRN) *(Date Signed)*

This form is to be submitted through the Arkansas Nurse Portal Message Center.

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