For Board Use Only
Date Filed: _____
Date Reviewed by Board: _____
Approved_____/ Not Approved _____
License #: _____

State of Maine Uniform Application for Approval of Collaborative or Practice Agreement

Maine Board of Osteopathic Licensure
142 State House Station
Augusta, ME 04333-0142
www.maine.gov/osteo

Maine Board of Licensure in Medicine
137 State House Station
Augusta, ME 04333-0137
www.maine.gov/md

I am submitting for approval (check one):

_____Collaborative Agreement: means a document agreed to by a physician associate and a physician that describes the scope of practice for the physician associate as determined by the practice setting and describes the decision-making process for a health care team, including communication and consultation among health care team members. A collaborative agreement is subject to review and approval by the Board.

_____Practice agreement: means a document agreed to by a physician associate who is the principal clinical provider in a practice and a physician that states the physician will be available to the physician associate for collaboration or consultation. A practice agreement is subject to review and approval by the Board.

Start Date: ____/_____/_____

Physician Associate Name		Maine License #
Proposed Practice Name and Address		
City	State, Zip Code	Business Phone#

Collaborating Physician Name MD ☐ DO ☐		Maine License #
Physician Primary Practice Name and Address		
City	State, Zip Code	Business Phone#

Scope of Practice/Medical Services and Procedures

A physician associate may provide any medical service for which the physician associate has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician associate is determined by the practice setting. Physician associate scope of practice delineated in collaborative agreements or practice agreements are subject to review and approval by the Board.

Please delineate the scope of the physician associate's practice and describe the medical services and procedures common to the practice that the physician associate will provide.

Scope of Practice:

Location where the physician associate will provide medical services.

Name of Facility	Street Address	City	Zip Code

Collaborative Arrangements

Describe the relationship of, and access to, the collaborating physician and a description of physician collaborative/consultative arrangements.

Education, Training and Employment

Please provide a chronological history of your education and your training and employment that is relevant to your proposed scope of practice in the collaborative or practice agreement:

Dates From/To (Month/Year)	Name & Address	Education, Training or Employment	Scope of Practice (Family, Cardiac, etc.)

We attest that the above information is true to the best of our knowledge and belief.

Physician Associate Signature Date

Collaborating Physician Signature Date

Attestation

By signing below, we certify that:

- We have read and understand the requirements of the Chapter 2 Joint Rule Regarding Physician Associates.
- We have read and understand the requirements of the Chapter 21 Joint Rule Use of Controlled Substances for the Treatment of Pain.
- We are in full compliance with the laws and regulations governing the practice of physician associates.
- We understand that the physician associate is legally liable for all medical acts performed by her/him and any medical acts delegated by the physician associate.
- We understand that the physician associate must keep a copy of the written collaborative/practice agreement at the main practice location and immediately produce it to the Board upon request.
- We understand that the Board may request a meeting with the physician associate to discuss the scope of practice proposed in any collaborative/practice agreement.
- We understand the following: the physician associate must be competent to provide the medical services delineated in the collaborative/practice agreement and must conform her/his scope of practice to the one delineated in the collaborative/practice agreement that has been approved by the Board. Any medical acts performed by the physician associate that are outside the scope of practice of the collaborative/practice agreement may constitute grounds for discipline.

This registration is jointly agreed to and submitted by (please sign and print your names below).

Physician Associate Name	Maine License #
Signature	Date

Collaborating Physician Name	Maine License #
Signature	Date