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

	am submitting for approval (check one)	:	
:ł	Collaborative Agreement: means a escribes the scope of practice for the phase decision-making process for a health are team members. A collaborative agree	nysician assistant as determined care team, including communica	by the practice setting and describes ation and consultation among health
2	Practice agreement: means a docurovider in a practice and a physician that ollaboration or consultation. A practice tart Date:	it states the physician will be ava	• •
	Physician Assistant Name		Maine License #
	Proposed Practice Name and Address		
	City	State, Zip Code	Business Phone#

6/16/2020

Collaborating Physician Name	MD L DOL	Maine License #	
Physician Primary Practice Name and Address			
City	State, Zip Code	Business Phone#	
Scope of Practice/Medical Services an	d Procedures		
A physician assistant may provide any medical service for which the physician assistant has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician assistant is determined by the practice setting. Physician assistant 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 ph procedures common to the practice the			
Scope of Practice:			

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Location where the physician assistant 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.			

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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:

Pates 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 Assistan	t Signature	Date	
Collaborating Physic	cian Signature	Date	

6/16/2020

Attestation

By signing below, we certify that:

- We have read and understand the requirements of the Chapter 2 Joint Rule Regarding Physician Assistants.
- 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 assistants.
- We understand that the physician assistant is legally liable for all medical acts performed by her/him and any medical acts delegated by the physician assistant.
- We understand that the physician assistant 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 assistant to discuss the scope of practice proposed in any collaborative/practice agreement.
- We understand the following: the physician assistant 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 assistant 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 Assistant Name	Maine License #
Signature	Date
Collaborating Physician Name	Maine License #
Signature	Date

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