

**ALLIED PROFESSIONAL DEPENDENT PRACTITIONER**

**COLLABORATING PRACTICE INFORMATION**

\*A copy of the protocol submitted to the state licensing body may be substituted for this form\*

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| Full Name: |       | Degree: |       |
| Specialty: |       | License Type: |       |

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| --- |
| Location where member services are provided: |
| Practice Name: |       |
| Address: |       |
| Phone: | (      )       -       | Fax: | (      )       -       |
| Hours of Operation: |       |

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| Type of member services to be provided: |
|       |
|       |
|       |

Please provide name, address and phone number of Practitioner with whom you have a collaborative agreement, if applicable (this section must be completed by those practitioners whose state license requires a protocol be entered into with a State License Physician).

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| Name of Collaborating Physician (Print) |       |
| Specialty: |       |
| Address: |       |
| Phone: | (      )       -       | Fax: | (      )       -       |

|  |  |
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|       |       |
| Signature of Collaborating Physician | Date |

Collaborating Physician is a Plan Participating Provider? [ ]  Yes [ ]  No