UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Restricted Associate Osteopathic Physician Collaborative Practice Agreement

A complete collaborative practice agreement consists of these written criteria, jointly developed by all parties involved, that permits an associate physician, working under the direction or review of a collaborating physician, to provide primary care services, and any additional pages.

Collaboration duration from _______________ to _____________.

RESTRICTED ASSOCIATE OSTEOPATHIC PHYSICIAN INFORMATION

Name: ____________________ ____________ ________________
First *Middle* *Last*

Home Address: ____

City: ____________________ State: __________ Zip: __________

Phone: (________) ______ – __________ Email: ____________________

Specialty/Board Certification(s): ______________________________

COLLABORATING PHYSICIAN INFORMATION

Name: __________ __________ ____________ License #__________
First *Middle* *Last*

Home Address: ____

City: ____________________ State: __________ Zip: __________

Phone: (________) ______ – __________ Email: ____________________

Specialty/Board Certification(s): ______________________________

Total number of restricted physicians associated with collaborating physician: ________

ESTABLISHMENT INFORMATION

If there are additional practice sites, please attach a complete list of all locations.

Note: *a physical copy of the complete* ***Collaborative Practice Agreement*** *must be available at all locations*

Establishment Name: ____

Address: ____

City: ____________________ State: __________ Zip: __________

Phone: (__________) _______ – ___________ Email: ____________________

The Collaborative Practice Agreement must adhere to requirements listed in the Utah Osteopathic Medical Practice Act, Utah Code§ 58-68-807 and the Utah Osteopathic Medical Practice Act Rule, Utah Administrative Code§ R156-68-807. It is the responsibility of all parties involved to familiarize themselves with the law.

A complete collaborative practice agreement, including all additional sheets, must be maintained at each practice site. Any change, amendment, update, or correction to this collaborative practice agreement must be submitted to the Division within 10 days of the changes.

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MANNER OF COLLABORATION

Specify the manner of collaboration including how the collaborating physician and the associate physician shall maintain geographic proximity and engage in collaborative practice consistent with each professional's skill, training, education, and competence.
(attach additional pages if necessary)

A copy of the entire "Collaboration Agreement" is required to be available at the practice site(s). The agreement must accurately reflect current practices.

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List procedures for providing oversight of the associate physician during the absence, incapacity, infirmity, or emergency of the collaborating physician.
(attach additional pages if necessary)

Please define procedures addressing how situations outside the associate physician's scope of practice will be handled.
(attach additional pages if necessary)

A copy of the entire "Collaboration Agreement" is required to be available at the practice site(s). The agreement must accurately reflect current practices.

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Describe the associate physician's controlled substance prescriptive authority Schedule III through V, and provide a comprehensive list of all of the controlled substances the collaborating physician authorizes the associate physician to prescribe *(attach additional pages if necessary):*

Describe your plan establishing educational methods and programs that the associate physician shall complete throughout the duration of the collaborative practice arrangement that will facilitate the advancement of the associate physician's medical knowledge and abilities.
(attach additional pages if necessary)

A copy of the entire Collaboration Agreement, including all additional pages, is required to be available at the practice site(s).
The agreement must accurately reflect current practices.

MANNER OF COLLABORATION

I understand that a collaborating physician is responsible, at all times, for the oversight of the activities of, and accepts responsibility for, the primary care services rendered by the associate Physician. I understand that before rendering any health care services the Division must approve this collaborative practice arrangement contract. As a signatory to this agreement, I will maintain required licensure and any required DEA registration and comply with the laws, rules, standards, and ethics of the profession.

I declare under criminal penalty under the law of Utah that the foregoing is true and correct.

Signature of Associate Physician: ______________________________ Date: ______________

Signature of Collaborating Physician: ______________________________ Date: ______________