



INSTRUCTIONS:

Add or Delete COVERING Physician
for
Certified Registered Nurse Practitioner (CRNP)
Or Certified Nurse Midwife (CNM)

1. Use this application to add or delete a covering physician to your existing protocol with a collaborating physician.
2. The applicant who is changing collaborating physician should use the application titled Add or Change Collaborative Practice.
3. This application is not intended for the CRNP or CNM applicant who has never applied for Collaborative Practice. Use the application for Initial Approval of Advanced Practice Nursing as a Certified Registered Nurse Practitioner or Certified Nurse Midwife.
4. A covering physician who is pre-approved by the State Board of Medical Examiners and is familiar with the rules for collaborative practice may provide medical coverage (back-up) in the event the collaborating physician is not readily available.
5. The attached covering physician agreement applies only to the collaborating physician named in this application.
6. The covering physician agreement lapses immediately when the CRNP/CNM or collaborating physician terminates the collaborative practice agreement.
7. Print legibly in black ink or type the required information.
8. Original signatures are required. Do not submit photocopy or fax copy of signatures.

9. Send the application, fee, and documents to: Alabama Board of Nursing P.O. Box 303900 Montgomery, Alabama 36130-3900.	If you want confirmation of delivery: Express Delivery should be addressed to: Alabama Board of Nursing 770 Washington Ave, Suite 250 Montgomery, AL 36104-3816.
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10. Confirmation of approved covering physician(s) will be mailed to the nurse and to the collaborating physician, at the address on file for each person in the records of the Alabama Board of Nursing.
11. If your name or address changes after you submit this application, immediately update your personal information on the ABN website www.abn.state.al.us > On-line Services. Submit a copy of marriage license, divorce decree or court order verifying the name change.
12. For more information, refer to our website at www.abn.alabama.gov or PHONE: 334-242-4060 , or TOLL FREE: 1-800-656-5318



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Montgomery, AL 36130-3900

PHONE: 334-242-4060 TOLL FREE: 1-800-656-5318
For more information, refer to our website at www.abn.alabama.gov

SPECIALTY AREA
Check (✓) applicable box for
your specialty area.

CRNP

CNM

**THERE IS NO FEE
FOR THIS SERVICE**

Mail the signed original application form to the Alabama Board Of Nursing.

LEGAL NAME _____
Last First Middle Maiden

LIST ANY PREVIOUSLY USED NAMES / ALIASES _____

SOCIAL SECURITY NUMBER _____ ALABAMA RN LICENSE NUMBER _____

PERMANENT STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

DAYTIME PHONE _____ FAX _____ EMAIL _____

The Covering Physician Agreement applies only to the COLLABORATING PHYSICIAN listed here:

Name: _____ License Number: _____

Address: _____

City, State, ZIP _____

TERMINATE THE FOLLOWING COVERING PHYSICIAN(S):

Physician Name	License Number	Effective Date of Termination

ADD THE FOLLOWING COVERING PHYSICIAN(S):

COVERING PHYSICIAN AGREEMENT

As a covering (back-up) physician providing medical guidance and direction for the applicant:

- I hereby affirm that I am familiar with the current regulations regarding CRNPs CNMs, and the collaborative practice protocol filed by the primary collaborating physician and CRNP /CNM named above.
- I approved the drug type, dosage, quantity, and number of refills of legend drugs that the CRNP/CNM is authorized to prescribe in the formulary included with the protocol.
- I will be accountable for providing oversight of the medical care rendered pursuant to the CRNP/CNM protocol during the temporary absence of the primary collaborating physician.

Provide the **mailing address for the new covering physician(s)** if different from the collaborating physician's address.

Signature of covering (back-up) physician	Date Signed	Name of the covering physician. (Type or print legibly.)	License Number

I affirm that the information recorded on this application concerning any item contained herein is true and correct. I understand that I may be required to submit documentation to support my affirmation. I further understand that any false statement is in violation of the Code of Alabama and the Board of Nursing Administrative Code and constitutes cause for disciplinary action.

SIGNATURE OF CRNP/CNM

DATE