Nurse Practitioner Form NP-CR

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Collaborative Relationships Attestation Form

To be completed by Certified Nurse Practitioners who have Collaborative Relationships Pursuant to Education Law §6902(3)(b)

Instructions

This form must be filled out and signed by nurse practitioners (with more than 3,600 hours of qualifying nurse practitioner practice experience) who choose to practice and have collaborative relationships - instead of practicing in accordance with a written practice agreement with a collaborating physician. Once completed, a nurse practitioner must keep this form at the nurse practitioner's practice location and provide it to the New York State Education Department upon request. The nurse practitioner must ensure that information on this form is current, and should complete a new Form NP-CR, as appropriate, to update information. Nurse practitioners who practice in accordance with a written practice agreement with a collaborating physician do not have to fill out a Form NP-CR.

1. Provide your name exactly as it appears on your current New York State Education Department issued nurse practitioner registration certificate(s):

   _____

2. Provide your nurse practitioner registration number(s):

   _____

3. Identify the specialty area(s) of nurse practitioner practice in which you are certified by the New York State Education Department:

☐ Acute Care	☐ Adult Health	☐ College Health
☐ Community Health	☐ Family Health	☐ Gerontology
☐ Holistic Nursing	☐ Neonatology	☐ Obstetrics and Gynecology
☐ Oncology	☐ Palliative Care	☐ Pediatrics
☐ Perinatology	☐ Psychiatry	☐ School Health
☐ Women's Health		

5. By placing your initials below, you attest that you are certified as a Nurse Practitioner in New York State and have more than 3,600 hours of experience practicing as a licensed or certified nurse practitioner pursuant to the laws of New York State or another State or working as a nurse practitioner for the United States veteran's administration, the United States armed forces or the United States public health service.

   Place initials here _____

6. By placing your initials below, you attest that you have collaborative relationships with one or more New York State licensed physicians qualified to collaborate in the specialty involved or with a New York State Department of Health licensed hospital that provides services through licensed physicians qualified to collaborate in the specialty involved and having privileges at such institution. A collaborative relationship means that you communicate, as required by New York State Education Department regulation, with the qualified physician for the purposes of exchanging information, as needed, in order to provide comprehensive patient care and to make referrals as necessary.

   Place initials here _____

7. By placing your initials below, you attest that you maintain current and accurate documentation supportive of your collaborative relationships and, upon request by New York State Education Department, you will produce evidence of the collaborative relationships, such as: (a) an agreement or an arrangement with a hospital or a physician practice pursuant to which you may transfer or refer patients for care; (b) written communications or records of consultations and communications for referral; (c) documentation of employment relationships with a physician practice or a hospital, hospice program, licensed home care services agency or licensed mental health care facility with a physician medical director; or (d) documentation of contractual relationship with a physician, physician practice, or a hospital, pursuant to which you provide professional services, or (e) (other please describe):

   _____

   Place initials here _____

8. Identify by name and license number physicians with whom you are currently engaged in collaborative relationships. If you have a collaborative relationship with a New York State Department of Health licensed hospital, include the name and address of the hospital.

_____

_____

_____

9. (Optional) You may provide additional information regarding your collaborative relationships here:

_____

_____

_____

_____

_____

_____

Attestation

I acknowledge that if reasonable efforts to resolve any dispute that may arise with a collaborating physician, or in the case of collaboration with a hospital, with a physician having professional privileges at such hospital, about a patient's care are not successful, the recommendation of the physician shall prevail.

I attest that, to the best of my knowledge, all information provided by me on this form are true as of the date of my signature below.

_____ _____

Signature of Nurse Practitioner Date

_____

Print Name