

APA-1  
6/93

TRANSMITTAL SHEET FOR  
NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners  
Rule No. 540-X-1, Appendix A  
Rule Title: Collaborative Practice Registration  
 New  Amend (repeal and replace)  Repeal  Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? NO

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? YES

Is there another, less restrictive method of regulation available that could adequately protect the public? NO

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree? NO

Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? NO

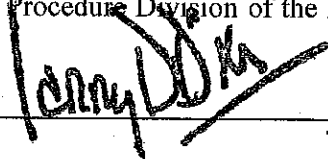
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? YES

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Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

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Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer 

Date: February 25, 2015

**ALABAMA STATE BOARD  
OF MEDICAL EXAMINERS**

**NOTICE OF INTENDED ACTION**

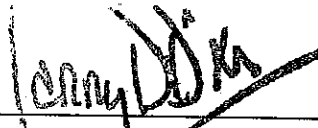
AGENCY NAME: Alabama State Board of Medical Examiners  
RULE NO. & TITLE: 540-X-1, Appendix A, Collaborative Practice Registration  
INTENDED ACTION: To amend the rule appendix by repeal/replace

SUBSTANCE OF PROPOSED ACTION: To amend the initial collaborative practice registration form to update the information elicited

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Patricia E. Shaner, General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including Tuesday, May 5, 2015. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Patricia E. Shaner, by telephone (334-242-4116) during said period in order to set up an appointment for a hearing respecting such oral data, views, or arguments.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: May 5, 2015

CONTACT PERSON AT AGENCY: Patricia E. Shaner, Esq.



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Larry D. Dixon, Executive Director

**REPEAL**

20\_\_ Collaborative Practice Registration  
<http://alrenewals.org>

Register online @

Deadline: December 31, 20\_\_

Registration ID:

Alabama Board of Medical Examiners  
P.O. Box 946, Montgomery, AL 36101  
(334) 242-4116

Complete ALL questions. Include a check for \$100.00 payable to the ALABAMA BOARD OF MEDICAL EXAMINERS for EACH Collaborative Practice.

Collaborative Practice Number:

CRNP / CNM License #:

Name of CRNP / CNM:

1. Does this nurse practitioner / nurse midwife work at a site other than your primary practice site? YES  NO   
(If yes, please list sites below. Please check the box next to the sites at which the nurse practitioner / nurse midwife practices with no physician on-site). If more space is needed, please submit additional pages in writing.

Practice Site Address: \_\_\_\_\_

Practice Site Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Practice Site Address: \_\_\_\_\_

Practice Site Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Are you employed by the nurse practitioner / nurse midwife in this collaborative practice to serve

as their collaborating physician at a clinic owned by him / her?

YES [ ] NO [ ]

3. Have you been audited by the Collaborative Practice Inspectors within the last 12 months? YES [ ] NO [ ]

4. Have you attended a Collaborative Practice Seminar in the last 24 months?

YES [ ] NO [ ]

5. Is your Quality Assurance Documentation up-to-date?

YES [ ] NO [ ]

I certify the foregoing information to be correct to the best of my knowledge, information and belief, and attest that I have reviewed and am abiding by the Rules and Regulations of Advanced Practice Nurses: Collaborative Practice, Chapter 540-X-8 that were effective on this date.

Signature \_\_\_\_\_

Date \_\_\_\_\_

FAILURE TO PAY THE ANNUAL FEE AND COMPLETE THE COLLABORATIVE PRACTICE REGISTRATION FORM WILL RESULT IN NOTIFICATION THAT THE PHYSICIAN DOES NOT CURRENTLY MEET THE QUALIFICATIONS NECESSARY FOR THE PHYSICIAN TO PARTICIPATE IN THE COLLABORATIVE PRACTICE AND THAT THE PHYSICIAN MUST CEASE PARTICIPATING IN THE COLLABORATIVE PRACTICE.

**REPLACE**ALABAMA BOARD OF MEDICAL EXAMINERS  
Commencement of Collaborative PracticeMailing Address:  
P.O. Box 946  
Montgomery, AL 36101-0946Physical Address:  
848 Washington Avenue  
Montgomery, AL 36104Phone: 334-242-4116  
Toll Free: 1-800-227-2606  
Website: www.albme.org**\*\*Send this signed original document and \$100.00 fee to the Alabama Board of Medical Examiners.\*\***Alabama Board of Medical Examiners  
Attn: Collaborative Practices Department

(Use one form per CRNP/CNM. Make additional copies as needed)

1. Physician's Name: \_\_\_\_\_ License Number: \_\_\_\_\_
2. Practice Address: \_\_\_\_\_
3. CRNP/CNM Name: \_\_\_\_\_ License Number: \_\_\_\_\_
4. CRNP/CNM Practice Address: \_\_\_\_\_
5. Date services to begin under this Collaborative Agreement \_\_\_\_\_

This is to certify that I, the undersigned physician agree and/or confirm:

1. The nurse practitioner/nurse mid-wife above and I will complete chart reviews for Quality Assurance as per the plan below and agree that 100% of all adverse actions will be reviewed for Quality Assurance.
2. The covering physicians listed in the application have knowledge and understanding of the Collaborative Practice Rules [Chapter 540-X-8] and are aware of their responsibilities.
3. Have an emergency plan/ policy in writing at the practice site.

## Quality Assurance Plan:

- A. Who will complete the chart reviews? \_\_\_ Physician \_\_\_ Nurse Practitioner \_\_\_ Other
- B. What is the time frame for your review? \_\_\_ Weekly \_\_\_ Monthly \_\_\_ Quarterly
- C. Selection of records for review to include records for patients treated by the CRNP/CNM
- D. Describe criteria for selecting records to be reviewed (give detail):

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I the undersigned physician have read and understand the Alabama Board of Medical Examiners Rules, Chapter 540-X-8, Advanced Practice Nursing: Collaborative Practice. It is also understood that my signature attests to these facts. Failure to adhere to these rules may result in an action against my license. It is also understood that I will complete written Termination upon the dissolution of this Collaborative Agreement.

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Original Signature Only)

Print Physician Name: \_\_\_\_\_

\*\*To alleviate a delay in approval of the Collaborative Practice, fill out the form completely and send upon submission of the application to the Board of Nursing. This Commencement Form will be returned if all of the information is not present and a check attached for the required fee.