623 SW 10th Avenue
Topeka, KS 66612
1.800.232.2259
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Collaborative Practice Agreement / Statement of Responsible Physician

(This document must be completed, signed, and returned with your completed application.)

Applicant's Name: _____ **License Number** ***(if applicable)*****:** _____

Collaborative or Responsible Physician's Name: _____

1. Provide a description of the physician's practice and the way in which the applicant is to be utilized—include applicant's routine duties, the type of practice, and the practice setting.

2. Identify the practice location(s) at which the applicant will routinely render professional services—include hospitals, if applicable.

I understand the collaborative or responsible physician will always be available for communication within thirty (30) minutes during the performance of patient service.

I have carefully read the above questions and have answered them completely, and my answers and all statement contained herein are true and correct.

_____ _____

Collaborative or Responsible Physician's Signature **Applicant's Signature**

_____ _____

Date **Date**