Nurse Practitioner Form 4NP

Area of current practice:

Area of specialty practice:

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

Department Use Only									
Approved									
Date									

Verification of Collaborative Agreement and Practice Protocol

Newly certified NPs (with more than 3,600 hours of qualifying NP experience) who choose to practice and have collaborative relationships as allowed by New York Law **SHOULD NOT** fill out Form 4NP. All other newly certified NPs must fill out and submit Form 4NP to the Office of the Professions.

of the Professions.																								
Applicant Instructions																								
1. 2.																								
Not	Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is only required <u>once</u> .																							
Sec	Section I: Applicant Information																							
1	Social Security Number																							
3	If Already Certified, New York State Nurse Practitioner Certificate Number																							
4	Print Name as It Appears on Your Application for a Certificate (Form 1)																							
	Last																							
	First																							
	Middle																							
5	5 Mailing Address (You must notify the Department promptly of any address or name changes.)																							
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	Line 3	F		İ	T												T					Ť	╡	
	City																İ	İ					_	-
	State Zip Code																			1				
	Country/ Province]
Section II: Collaborating Physician																								
1.	Name o	of col	llabo	rati	ng p	hys	icia	n:																
2.	2. Address:							Last									F	⊏irs	rst Middle					
۷.	Address	o																						
3.	Telepho	ne: _													Fa	x: _								
4.	E-mail a	addre	ess:																					
5.	5. New York State medical license number:																							

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Se	ction III: Practic	e Protocol													
Ins	appro		nstructions, pages 8-	at is a standard publication. 9) and submit this form to to nt of practice.				of the							
1.	List title, publish	her, and date of publication	n of the approved pr	rotocol text.											
2.	Location and description of practice site(s): (clinic, private office, HMO, etc.)														
				Practice Site											
		Name		Address		Descriptio	n								
3.	Description of p	practice including any mutu	ually agreed upon ex	ceptions:											
4.	We hereby verify that we have a written a collaborative agreement and have selected a practice protocol(s).														
	Nurse Practition	ner signature:			Date:	mo. day	/	yr.							
	Collaborating P	Physician signature:			Date:	/ day	_ /	yr.							
Re	turn Directly to:	New York State Educat	tion Department. O	ffice of the Professions, I	Division of Profess		g Serv								

Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.

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