Nurse Practitioner Form 4NP

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

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1).
2. You and the initial collaborating physician with whom you have a practice agreement and practice protocol must complete Sections II and III and return both pages of the form to the Office of the Professions at the address at the end of the form.**.** Be sure to sign and date item 4 in Section III.

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 **once**.

Section I: Applicant Information

1 **Social Security Number** ☐☐☐ ☐☐ ☐☐☐☐ **2** **Birth Date** Month ☐☐ Day ☐☐ Year ☐☐

(Leave this blank if you do not have a U.S. 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 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 2 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 3 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State ☐☐ Zip Code ☐☐☐☐☐ ☐☐☐☐

Country/ Province ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section II: Collaborating Physician

1. Name of collaborating physician: _____
   Last *First* *Middle*
2. Address: _____
   _____
3. Telephone: _____ Fax: _____
4. E-mail address: _____
5. New York State medical license number: _____
6. Area of current practice: _____
7. Area of specialty practice: _____

Section III: Practice Protocol

Instructions: You must use an approved practice protocol text that is a standard publication. Please select a protocol text from the approved list (see application instructions, pages 8-9) and submit this form to the Department at the address at the end of the form, no later than 90 days after the commencement of practice.

1. List title, publisher, and date of publication of the approved protocol text.

_____

_____

_____

2. Location and description of practice site(s): (clinic, private office, HMO, etc.)

Practice Site		
Name	**Address**	**Description**

3. Description of practice including any mutually agreed upon exceptions:

_____

_____

_____

_____

4. We hereby verify that we have a written a collaborative agreement and have selected a practice protocol(s).

Nurse Practitioner signature: _____ Date: _____ / _____ / _____
mo. day yr.

Collaborating Physician signature: _____ Date: _____ / _____ / _____
mo. day yr.

Return Directly to: **New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.**