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Oklahoma City, OK 73134

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Collaborative Practice Information for
Allied Health Professional Dependent Practitioners

_____

Name of Allied Health Professional License Type Specialty

Location where member services are to be provided:_____

_____

_____

Type of member services to be provided:_____

_____

Signing this agreement will indicate that the Collaborative physician will provide the following coverage if necessary: prescribing, hospitalization, & supervising.

_____

Name of Collaborating Physician **(please print)** Specialty

_____ _____

Signature of Collaborating Physician Date

Collaborating Physician is a Plan participating provider Yes No

A copy of the protocol submitted to the state licensing body may be substituted for this form.

2020