Collaborative Agreement Form

Once signed and dated by the appropriate person(s) this form and any supporting documentation must be sent on or before **October 15th** of each year to DHSS_DPH_SBHC@delaware.gov.

A collaborative agreement is required for each APRN at site.

Name of Vendor: _____

Name of SBHC: _____

Full Name of Licensed Practitioner: _____

Licensed Practitioner is certified as a: _____

Name of Physician signing this document: _____

Physician is certified as a: _____

Collaborative Agreement: In subsequent years of this agreement, if there are NO changes, the License Practitioner named on this document will sign and date a new form and indicate that there are no changes. Please select one option from the following:

☐ There are no changes to the Collaborative Agreement dated: _____

Signature of Licensed Practitioner: _____ Date: _____

OR

☐ There are changes to the previous Collaborative Agreement effective: _____
(Please include supporting documentation when submitting.)

Signature of Licensed Practitioner: _____ Date: _____

Signature of Physician: _____ Date: _____