COLLABORATIVE PHYSICIAN AGREEMENT

In providing care to Health Alliance Plan of Michigan members, I,

_____ MD/DO agree to collaborate with

_____ NP/PA.

1. I confirm that I am the Collaborating Physician for the above-named Nurse Practitioner or Physician Assistant.

2. I agree to abide by all laws, rules and regulations, including policies and procedures governing the collaboration of Nurse Practitioners or Physician Assistants at Health Alliance Plan of Michigan participating hospitals.

3. I agree to inform Health Alliance Plan of Michigan in the event that I have concerns with regard to the quality of care provided by the Collaborative Nurse Practitioner or Physician Assistant.

4. I agree to immediately notify Health Alliance Plan of Michigan in the event the scope or nature of my professional affiliation with the Collaborative Nurse Practitioner or Physician Assistant changes.

5. I agree to comply with all regulations of the State Medical Board and the Michigan Public Health Code with respect to my supervision of the Collaborative Nurse Practitioner or Physician Assistant.

_____

Signature, Collaborative Physician Date

Email completed, signed form to providernetwork@hap.org. Please put "collaborative agreement" in the subject line.