

LIMITED LICENSE COLLABORATIVE PRACTICE ATTESTATION

Limited License Holder: _____ Effective Date of Agreement: _____

Collaborating Physician: _____ Duration of Agreement: _____

In accordance with **Minnesota Statutes, section 147.037, subd. 1b(a)(2) and (h)**,

The limited license holder and one of the collaborating physicians must have experience in providing care to patients with the same or similar medical conditions. Under the collaborative agreement, the following terms must be met:

- The limited license holder must shadow the collaborating physician for four weeks.
- After the four weeks of shadowing the collaborative physician, the limited license holder must staff all patient encounters with the collaborating physician for an additional four weeks.
- After these first eight weeks of shadowing and staffing all patient encounters, the collaborating physician has discretion to allow the limited license holder to see patients independently and may, at the discretion of the collaborating physician, require the limited license holder to present patients.
- The limited license holder must continue to be supervised by the collaborating physician for a minimum of two hours per week for the duration of the time the limited license is active.
- The limited license holder must have one-on-one practice reviews with each collaborating physician, provided in person or through eye-to-eye electronic media while maintaining visual contact, for at least two hours per week.
- A limited license holder may practice medicine without a collaborating physician physically present, but the limited license holder and collaborating physicians must be able to easily contact each other by radio, telephone, or other telecommunication device while the limited license holder practices medicine.

APPLICANT/LICENSEE INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME	
STREET ADDRESS			
CITY	STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY
BIRTH DATE (mm/dd/yyyy)			

COLLABORATING PHYSICIAN INFORMATION		
NAME	PHONE NUMBER	EMAIL
PRACTICE SPECIALTY	PRACTICE SITE NAME/LOCATION	LICENSE NUMBER

The undersigned attest that the physician limited license holder is practicing under a collaborative practice agreement that complies with Minnesota Statutes, section 147.037, subd. 1b(a)(2) and (h).

Limited License Holder: _____
Print Name Signature Date (mm/dd/yyyy)

Collaborating Physician: _____
Print Name Signature Date (mm/dd/yyyy)