SAMPLE COLLABORATION AGREEMENT TEMPLATE

Revised 06/2024

Per ORS 677.495, a collaboration agreement is a written agreement that describes the manner in which the physician associate collaborates with physicians (MD/DO/DPM), that does not assign supervisory responsibility to, or represent acceptance of legal responsibility by, a physician for the care provided by the physician associate and that is signed by the physician associate and the physician or physician associate's employer.

Collaboration means, as indicated by the patient's condition, community standards of care and a physician associate's education, training and experience: (a) Consultation between the physician associate and a physician; or (b) Referral by the physician associate to a physician. Community standards of care means that degree of care, skill, and diligence that is used by ordinarily careful licensees in the same or similar circumstances in the licensee's community or a similar community.

Beginning date for Collaboration Agreement (mm/dd/yyyy):_____

Physician Associate Information:

Last Name	First Name	Middle Initial	Oregon License Number

Primary Practice Location Name	Primary Practice Street Address, City, State, and Zip Code

Business Phone	Business Email	NCCPA ID Number (optional)

Employer Representative or Physician (MD/DO/DPM) Information:

Last Name	First Name	Middle Initial	Oregon License Number *If applicable*

COLLABORATION

A general description of the physician associate's process for collaboration with physicians (MD/DO/DPM) and if applicable, include any differences in the process for collaboration based on practice location. The description may also include additional requirements specific to the physician associate's practice, including additional levels of oversight, limitations on autonomous judgment, and designating a primary contact for collaboration:

Note: By OAR 847-050-0041(2), a physician associate may issue prescriptions based on the physician associate's education, training, experience, and commensurate with the collaboration agreement, thus, prescribing does not have to be specifically included in the process for collaboration.

Does the physician associate have at least 2,000 hours of post-graduate clinical experience?
"Post-graduate clinical experience" means professional practice as a physician associate applying principles and methods to provide assessment, diagnosis, and treatment of patients.

- ☐ Yes, the physician associate must provide evidence of post-graduate clinical experience to the physician or employer entering the collaboration agreement. The physician or employer is responsible for determining if the physician associate meets the 2,000 hour requirement and does not require a Specified Collaboration Plan.
- ☐ No, include Attachment A: Specified Collaboration Plan (see page 4)

REVIEW

The collaboration agreement review process:

AGREEMENT REQUIREMENTS

- A collaboration agreement must be replaced or amended in writing to add, remove, or change requirements.
- The collaboration agreement must be available at the physician associate's primary location of practice and made available to the Oregon Medical Board upon request.
- The physician associate must be provided with a copy of the collaboration agreement and any amendments.
- The physician associate and the physician or employer with whom the physician associate has entered into the collaboration agreement is responsible for upholding the terms of the collaboration agreement and ensuring availability for collaboration.
- ORS 677.495 to 677.535 and OAR 847 chapter 50 provides the requirements for physician associate practice in Oregon.

SIGNATURES

Signature of Employer Representative or Physician:_____

Name of Employer Representative or Physician:_____ Date:_____

Title of Employer Representative or Physician:_____

Signature of Physician Associate:_____

Name of Physician Associate:_____ Date:_____

TERMINATION
To be completed when collaboration agreement is terminated.

Termination date for Collaboration Agreement (mm/dd/yyyy):_____

SIGNATURES

Signature of Employer Representative or Physician:_____

Name of Employer Representative or Physician:_____ Date:_____

Title of Employer Representative or Physician:_____

Signature of Physician Associate:_____

Name of Physician Associate:_____ Date:_____

Attachment A: Specified Collaboration Plan

If the physician associate has fewer than 2,000 hours of post-graduate clinical experience, a plan for consistent and quality collaboration with a specified physician (MD, DO, DPM) on a regular basis. Collaboration with a specified physician may occur in person and through synchronous and asynchronous technology.

A collaboration agreement must be amended in writing to remove or modify a Specified Collaboration Plan.

Physician Associate Information:

Last Name	First Name	Middle Initial	Oregon License Number

Physician (MD/DO/DPM) Information:

Last Name	First Name	Middle Initial	Oregon License Number *If applicable*

Description of specified collaboration: