IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is subject to discipline under the Act.

Notice of Termination of Collaboration and/or Delegated Authority (Physician Assistant)

COLLABORATING PHYSICIAN: If you are no longer collaborating with a physician assistant or if you have terminated delegated prescriptive authority for a physician assistant, you must submit a NOTICE OF TERMINATION OF COLLABORATION AND/OR DELEGATED AUTHORITY (PHYSICIAN ASSISTANT) to the Department within 10 days of termination.

Completed forms may be Emailed to: **FPR.MedicalUnit@illinois.gov**; Faxed to 217-524-2169; or Mailed to: IDFPR – Division of Professional Regulation, 320 West Washington Street, 3rd Floor, Springfield, IL 62786.

All forms must be typed or legibility printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at **www.idfpr.gov** to ensure you are using the current forms. **Please allow 4-6 weeks for processing of new applications and changes in collaboration and/or delegation.**

PHYSICIAN ASSISTANT INFORMATION

1. NAME OF PHYSICIAN ASSISTANT	2. ILLINOIS LICENSE NUMBERS 085-_____ 385-_____
3. HOME/CELL NUMBER FOR PHYSICIAN ASSISTANT ( ) _____	4. PERSONAL EMAIL FOR PHYSICIAN ASSISTANT _____

Signature _____

COLLABORATING PHYSICIAN INFORMATION

1. PHYSICIAN NAME	2. ILLINOIS LICENSE NUMBERS 036-_____ 336-_____
3. ILLINOIS PRACTICE ADDRESS (Street, City, State, Zip Code)	4. ILLINOIS PHONE NUMBER OF PRACTICE (Include Area Code) ( ) _____
	5. ILLINOIS MEDICAL STAFF/CREDENTIALING OR PHYSICIAN Fax: ( ) _____ Email: _____

Date Collaboration Agreement and Delegated Prescriptive Authority was Terminated: _____
Month - Day - Year

Signature of Collaborating Physician: _____ Date Signed _____

COMPLETE THIS SECTION IF YOU ARE ONLY TERMINATING DELEGATED PRESCRIPTIVE AUTHORITY BUT WILL CONTINUE A COLLABORATIVE AGREEMENT WITH THE PHYSICIAN ASSISTANT NAMED ABOVE

1. PHYSICIAN NAME	2. ILLINOIS LICENSE NUMBERS 036-_____ 336-_____
3. ILLINOIS PRACTICE ADDRESS (Street, City, State, Zip Code)	4. ILLINOIS PHONE NUMBER OF PRACTICE (Include Area Code) ( ) _____
	5. ILLINOIS MEDICAL STAFF/CREDENTIALING OR PHYSICIAN Fax: ( ) _____ Email: _____

Date Delegated Prescriptive Authority was Terminated: _____
Month - Day - Year

Signature of Collaborating Physician: _____ Date Signed _____