COLLABORATION AGREEMENT TEMPLATE DRAFT

Revised 4/2022

Per ORS 677.495, a collaboration agreement is a written agreement that describes the manner in which the physician assistant 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 assistant and that is signed by the physician assistant and the physician or physician assistant's employer.

Collaboration means, as indicated by the patient's condition, community standards of care and a physician assistant's education, training and experience: (a) Consultation between the physician assistant and a physician; or (b) Referral by the physician assistant 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 Assistant Information:

Last Name	First Name	Middle Initial	Oregon License Number

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

Business Email	Business Phone

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 assistant'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 assistant's practice, including additional levels of oversight, limitations on autonomous judgment, and designating a primary contact for collaboration:

SAMPLE

DRAFT, Sample Template, Reference Purposes Only

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

☐ Yes, the physician assistant 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 the physician assistant meets the 2,000 hour requirement and does not require a Specified Collaboration Plan.

☐ No, include Attachment A: Specified Collaboration Plan (see page 4)

ASSESSMENT & REVIEW
The performance assessment and 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 assistant's primary location of practice and made available to the Oregon Medical Board upon request.
- The physician assistant must be provided a copy of the collaboration agreement and any amendments.
- The physician assistant and the physician or employer with whom the physician assistant 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 assistant 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 Assistant:______________________________

Name of Physician Assistant:______________________________ Date:______________

SAMPLE

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 Assistant:____

Name of Physician Assistant:____ Date:________________

SAMPLE

DRAFT, Sample Template, Reference Purposes Only

Attachment A: Specified Collaboration Plan
If the physician assistant 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 Assistant 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:

SAMPLE