P.O. Box 31400
Tampa, FL 33631-3400
Tel: **1-813-290-6254** Fax: **1 - 813-290-6252**

Collaborative Practice Information for
Allied Health Professional Dependent Practitioners

_____
Name of Allied Health Professional License Type Specialty

Location where member services are to be provided:_____

_____

_____

Type of member services to be provided: _____

_____

_____

_____

_____ _____
Name of Collaborating Physician **(please print)** Specialty

_____ _____
Signature of Collaborating Physician Date

Collaborating Physician is a Plan participating provider Yes No

A copy of the protocol submitted to the state licensing body may be substituted for this form.

2008