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)

PHYSICIAN: If you terminate the collaborative agreement with a physician assistant on your record, you are required to submit the NOTICE OF TERMINATION OF COLLABORATION AND/OR DELEGATED AUTHORITY within ***10*** days of termination.

IDFPR - Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786
Fax: 217-524-2169
Email: FPR.MedicalUnit@illinois.gov

All forms must be typed or legibility printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at www.idfpr.com to ensure you are using the current forms. **Please allow 4-6 weeks from receipt for processing.**

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

Signature of Physician: _____ Date Signed _____

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

1. COLLABORATING 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 Physician: _____ Date Signed _____