ADDENDUM TO COLLABORATIVE PLAN

Instructions: Use this form to add additional alternate collaborating physicians to your collaborative plan. This form may be submitted separately or as an attachment to a collaborative plan. Please print or type.

Physician Assistant	Primary Collaborating Physician

ALTERNATE COLLABORATING PHYSICIAN'S STATEMENT

I hereby certify that I am familiar with the statutes and regulations of the State of Alaska governing the activities and responsibilities of a collaborating physician and that I will fulfill those responsibilities in this collaborative agreement in the absence of the primary collaborating physician. In entering into this agreement as alternate collaborating physician, I accept professional or employer liability to patients of the physician assistant for whom malpractice is adjudged. I have retained a copy of this agreement for my records. I will also maintain and make available for audit by the State of Alaska any performance assessment records which are generated as a result of this collaborative agreement in my capacity as alternate collaborating physician.

1

Signature				Date
Printed Name				AK License No.
Address	City	State	Zip	Telephone

2

Signature				Date
Printed Name				AK License No.
Address	City	State	Zip	Telephone

3

Signature				Date
Printed Name				AK License No.
Address	City	State	Zip	Telephone