

Return To: Computer Sciences Corporation  
PO Box 4610  
Rensselaer NY 12144-4610

## COLLABORATING PHYSICIAN CERTIFICATION FORM

This form must be completed and signed by your collaborating physician.

Physician Name: \_\_\_\_\_

Physician License Number: \_\_\_\_\_

Physician National Provider Identifier (NPI) (Required): \_\_\_\_\_

Physician Medicaid Provider # (Required): \_\_\_\_\_

Physician Current Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Certification Statement:

In accordance with the requirements of the laws and regulations of the State Department of Education, I have established a collaborative agreement and practice protocols with

\_\_\_\_\_. Effective \_\_\_\_\_.  
(Name of Nurse Practitioner) (Date of Agreement)

Nurse Practitioner National Provider Identifier (NPI) (Required): \_\_\_\_\_

Nurse Practitioner Medicaid Provider # (Required): \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_