State of South Carolina
Department of Health and Human Services

PRECEPTOR/PROTOCOL AGREEMENT FORM

1. A Nurse Practitioner, Nurse Midwife, Clinical Nurse Specialist, or Physician Assistant practicing in an extended role shall perform delegated medical acts pursuant to an approved written protocol between the nurse or physician assistant and the physician.

2. The approved written protocol shall include the following information at a minimum:

   A. General Data:

      1. Name, address, and license number of the nurse or physician assistant.
      2. Name, address, and license number of the physician preceptor/collaborator.
      3. Nature of practice and practice location(s) of the nurse or physician assistant and the physician.
      4. Date the protocol was developed and dates reviewed and amended.
      5. Description of how consultation with the physician is provided and if a provision for backup consultation has been established in the physician's absence.

   B. Delegated Medical Acts:

      1. The medical conditions for which therapies may be initiated, continued or modified.
      2. The treatments that may be initiated continued or modified.
      3. The drug therapies that may be prescribed.
      4. Situations that require direct evaluation by or referral to the physician.

3. The original protocol and any amendments to the protocol, dated and signed by the nurse or physician assistant and the physician, shall be available for review within 72 hours of request.

4. Individuals, who change practice settings or physicians, shall notify the Department of Health and Human Services (DHHS) in writing within 15 days. Individuals who discontinue their practice shall notify DHHS in writing within 15 days.

I, the undersigned, agree to serve as the physician preceptor/collaborator for ______________________ ____________________________________. My preceptorship is to extend to the limits described in the above written protocol.

______________________________	______________________________
Physician Printed Name	Enrollee Printed Name
______________________________	______________________________
Physician Signature	Enrollee Signature
______________________________	______________________________
Physician License #	Physician Assistant or Nurse License #
______________________________	______________________________
Physician NPI #	Physician Assistant or Nurse NPI #

Date______________________________

PLEASE FAX THIS COMPLETED FORM TO: Medicaid Provider Enrollment - (803) 870-9022