State of Illinois
Department of Healthcare and Family Services

Advance Practice Nurse (APN) Certification and Collaborative Agreement Form

Provider Information			
Last Name, First Name, Middle Initial	Provider Number	License Number	
Office Address	City	State	Zip Code
Office Phone	After Hours Phone	Fax Number	

APN Certifications Include: (Check all that apply)

☐ Certified Nurse Midwife ☐ Certified Registered Nurse Anesthetist

☐ Certified Nurse Practitioner Specialty(s):_____

☐ Clinical Nurse Specialist Specialty(s):_____

Collaborating Physician(s):

Physician Name	Physician Address	Physician FEIN	Physician License Number	State of Licensure
				AL
				AL
				AL
				AL

For CRNAs who are not required to maintain a collaborative or written practice agreement, list the following information:

Hospital Name	Street Address/City/State/Zip	Phone

Certification

I certify that I meet the participation requirements for an Advance Practice Nurse. I also understand that I must notify the Department in writing should any changes to the information contained herein become necessary. I also understand that the information I enter on this form will be used to update the Department's data base.

Provider Signature _____ **Date** _____

Please mail your original signed copy to: **Healthcare & Family Services**
Provider Participation Unit
P. O. Box 19114
Springfield, Illinois 62794-9114

For more information, call: (217) 782-0538