STATE OF MARYLAND

Board of NURSING

MARYLAND BOARD OF NURSING
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Type into this form, print & sign your name. If you are unable to type into the form, you may print it and print your information legibly in ink. Return by mail or e-mail the scanned, **signed and dated** form. We recommend you retain a copy for your records. If you have any questions, call the Advanced Practice department at (410) 585-1926.

NURSE ANESTHETIST NOTIFICATION OF COLLABORATION

Your Name**:** _____
(Type name as it appears on your license)

Maryland RN ***or*** AC License #:_____
(Type license number)

COLLABORATING ANESTHESIOLOGIST, PHYSICIAN OR DENTIST

Name:_____
(Type collaborator's name as it appears on his/her license)

License Number: _____
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Licensee's Signature:_____ Date Signed: _____
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MAIL OR EMAIL A SIGNED AND DATED COPY TO:

Maryland Board of Nursing, Advanced Practice Unit
4140 Patterson Avenue
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