

DISSOLVEMENT/TERMINATION OF COLLABORATIVE AGREEMENT

NAME: _____
Please Print

RXA NUMBER _____

LICENSE NUMBER _____

DEA NUMBER _____

COLLABORATIVE AGREEMENT DISSOLVED EFFECTIVE: _____
Date

Name of Collaborative Physician: _____ MD DO
Please Print

Business Address: _____

City, State, Zip Code _____

Business Phone: _____

West Virginia Medical License number: _____

Reason for dissolution of collaborative agreement: _____

Prescriber's Signature _____ Date _____

SUBSCRIBED AND SWORN TO BEFORE ME this _____ day of
_____ 20 _____

My commission expires _____

(SEAL)

Signature of Notary Public