

NP & PA Collaboration Law: 50-State Reference Guide

*A Framework for Operationalizing
Clinical Collaboration & Ongoing Compliance*

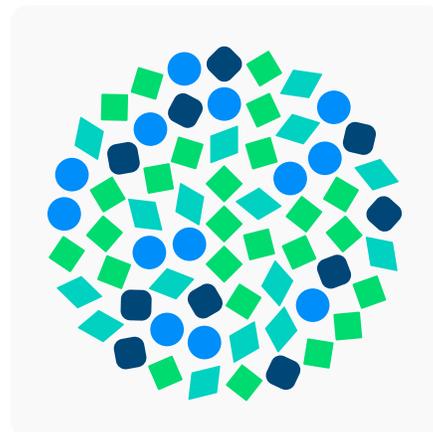
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About This Report

Care delivery in the United States is rapidly evolving alongside shifts in workforce composition and patient demand. Nurse practitioners (NPs) and physician assistants (PAs), collectively referred to in this report as advanced practice providers (APPs), have become some of the fastest growing professions in healthcare and play an increasingly visible role in how clinical teams are structured. **NP and PA roles are expected to grow by 40 percent and 28 percent respectively by 2033, outpacing projected physician growth by more than tenfold.**



But deploying APPs at scale comes with a compliance infrastructure that many organizations underestimate. In most states, APPs must maintain a formal professional relationship with a physician as a condition of practice. These states set forth expectations around physician involvement, prescriptive authority, and structured oversight. Requirements vary widely across states and reflect decades of layered legislative development, creating compliance obligations that recur on defined timelines and span multiple departments. Many organizations still manage this compliance work manually without centralized visibility.

However, managing collaboration compliance as an integrated part of clinical operations — rather than a back-office administrative burden — is increasingly a structural advantage in markets where APP-integrated care models are the growth vehicle.

The organizations that recognize collaboration law as an active operational variable move faster and scale more responsibly.

This report provides a detailed overview of NP and PA collaboration laws and practice authority frameworks across the United States.

It organizes state variation into defined categories, explains the structural components of collaboration agreements, and outlines ongoing oversight requirements.

This report also features Zivian's Regulatory Spectrum — a framework that goes beyond traditional state categorizations to evaluate how physician-APP relationships are actually structured and how they operate in practice, offering a more operationally useful view of state-level differences than traditional practice authority categories alone.

Key Takeaways



Modern Landscape: Practice Environments | 05

Traditional practice environment categories are a useful starting point for understanding collaboration law, but they can obscure the operational realities of APP deployment.



Zivian's Regulatory Spectrum | 10

APP regulation is better understood as a spectrum than a set of static legal labels. Zivian's Regulatory Spectrum offers a more practical view of how collaborations actually function in healthcare operations.



Collaboration Agreements in Practice | 15

A collaboration agreement is a living document that translates state law into a working clinical relationship, defining how oversight and accountability are structured in practice.



Ongoing Collaboration Compliance | 18

Collaboration compliance rules vary widely across states but often require ongoing oversight activities that must be actively tracked and maintained over time.



Regulatory Watch: Recent and Upcoming Changes | 30

The APP regulatory landscape continues to evolve in ways that can create meaningful operational impact for healthcare enterprises.



Historical Context & The Road Ahead | 38

Today's fragmented regulatory environment is the result of decades of incremental reform layered onto different professional models and state priorities. Navigating APP oversight successfully at scale requires purpose-built operational infrastructure.

About the Authors

Zivian's team brings deep experience at the intersection of clinical operations, healthcare regulation, and multi-state workforce scaling. We combine legal and compliance expertise with hands-on experience building healthcare operations software that supports modern care models.



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CEO, Zivian

Griffin Mulcahey is a digital health entrepreneur with over a decade of experience in healthcare innovation. Prior to joining Zivian, Mulcahey was the co-founder of Wheel Health, Inc., a B2B telehealth technology platform and provider marketplace. With a background as both an attorney (HHS & Epstein Becker & Green, PC) and startup executive, Griffin brings unique insights into healthcare regulatory compliance, commercial strategy, and scaling innovative healthcare product solutions.



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Ramsey is a healthcare regulatory attorney who has spent his career navigating complex regulatory frameworks and bringing innovative care infrastructure to market within health technology companies. Before practicing law, he gained firsthand experience in patient care and clinical operations, including seven years as a pharmacy technician. He brings a practical, implementation-focused approach to translating regulatory requirements into clear guidance that supports compliant operations at scale.



Modern Landscape: Practice Environments

Before reviewing state-by-state rules, it helps to start with traditional definitions for NP and PA practice authority.

Practice environment categories established by the [American Academy of Physician Associates \(AAPA\)](#) and the [American Association of Nurse Practitioners \(AANP\)](#) offer a widely used snapshot of how states structure physician involvement and APP autonomy, providing a useful baseline for comparing practice environments across jurisdictions.



Today's Regulatory Landscape for NPs & PAs

The roots of today's regulatory complexity for NPs and PAs run deep — a product of decades of incremental legislative development layered onto evolving clinical practice models.

Today, NP and PA practice authority reflects a combination of long-standing statutory frameworks and more recent legislative reforms. Although many states have updated their laws, physician-APP relationship requirements remain defined at the state level and continue to differ across jurisdictions.

These frameworks were not designed at a single moment in time. Instead, they reflect gradual adjustments to workforce pressures, professional advocacy, and patient access needs. As a result, present-day laws often combine legacy supervisory structures with newer autonomy provisions, creating regulatory models that vary in terminology, structure and practical effect.

It's important to note that while both professions have evolved over time, the structure of physician involvement differs significantly between PAs and NPs.

While both professions have evolved over time, the structure of physician involvement differs between PAs and NPs.

The Practice Authority Spectrum



Key Differences Between NPs and PAs



Physician Assistants

Generally operate under more restrictive supervisory models.



Nurse Practitioners

Increasingly moving toward greater autonomy. 19 states and DC grant full practice authority. 15 offer transition to independence.

Physician Assistants

For PAs, supervision remains the structural foundation of practice in most states. PAs are licensed under medical boards and, in the majority of states, must maintain a formal supervisory relationship with a physician as a condition of practice.

Although the terminology has shifted in some states—from "supervision" to "collaboration" or "delegation"—the core requirement for physician involvement generally remains in place. States vary in how they define that involvement. Some require written supervisory agreements, defined oversight activities, or ratio limits. Others provide more flexibility in how supervision is structured.

Even where supervisory rules have been updated, most states continue to require an ongoing physician relationship for PAs.

As a result, PA practice authority is best understood not as independent versus supervised, but as existing along a continuum of physician involvement.

The table below reflects the AAPA's practice environment categories, which classify PA practice authority across four levels based on state law and regulatory requirements.

Practice Environment	AAPA Definition
Reduced	State law and/or regulation restrict the healthcare team and PAs' ability to practice in at least one element of PA practice. Requires outdated practice models of limited delegated authority and/or restrictive supervision requirements.
Moderate	State law and/or regulation requires additional administrative burdens that impact the practice environment. The PA and the healthcare team are limited in flexibility due to these administrative burdens.
Advanced	PAs practice to the full extent of their medical education, training, and experience, but must comply with additional administrative requirements as mandated in state law and/or regulation.
Optimal	PAs can practice to the full extent of their medical education, training, and experience. PAs continue to collaborate, consult, and/or refer to the appropriate member(s) of the healthcare team as indicated by the patient's condition, the PA's competencies, and the standard of care. The healthcare team, and/or their employer, may establish guidelines for collaboration, consultation, and/or referral beyond state laws and regulations.

Nurse Practitioners

For NPs, states traditionally fall into three commonly used categories: restricted practice, reduced practice, and full practice.

In restricted practice states, NPs must maintain a physician relationship for both practice and prescriptive authority. In reduced practice states, NPs may practice with some degree of autonomy but must maintain physician collaboration for certain elements of care, such as prescribing. In full practice states, NPs may practice independently, without mandated physician collaboration.

In recent years, many states have moved toward full practice authority. However, in some of those states, independence is not immediate, and NPs are required to complete a defined period of collaborative practice before full autonomy is granted. This is commonly referred to as "transition-to-independence."

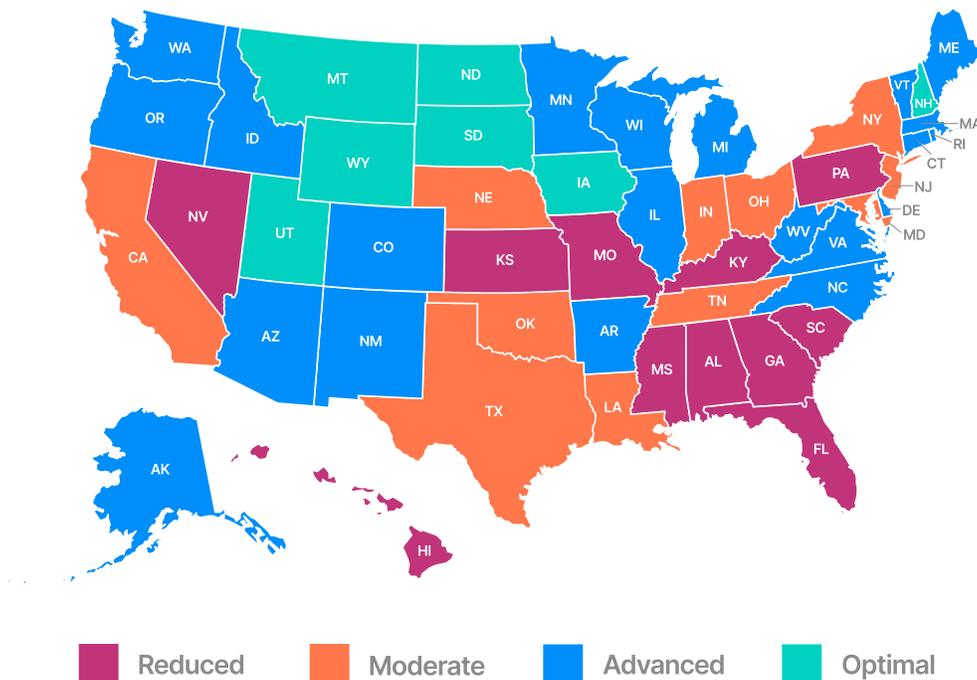
These traditional categories provide a useful starting point for understanding modern NP collaboration laws. At the same time, they do not fully capture the operational differences between states, as state rules vary widely and often change after NPs reach certain thresholds of experience.

The table below reflects the AANP's practice authority categories, which classify NP practice authority across three levels based on state law and regulatory requirements.

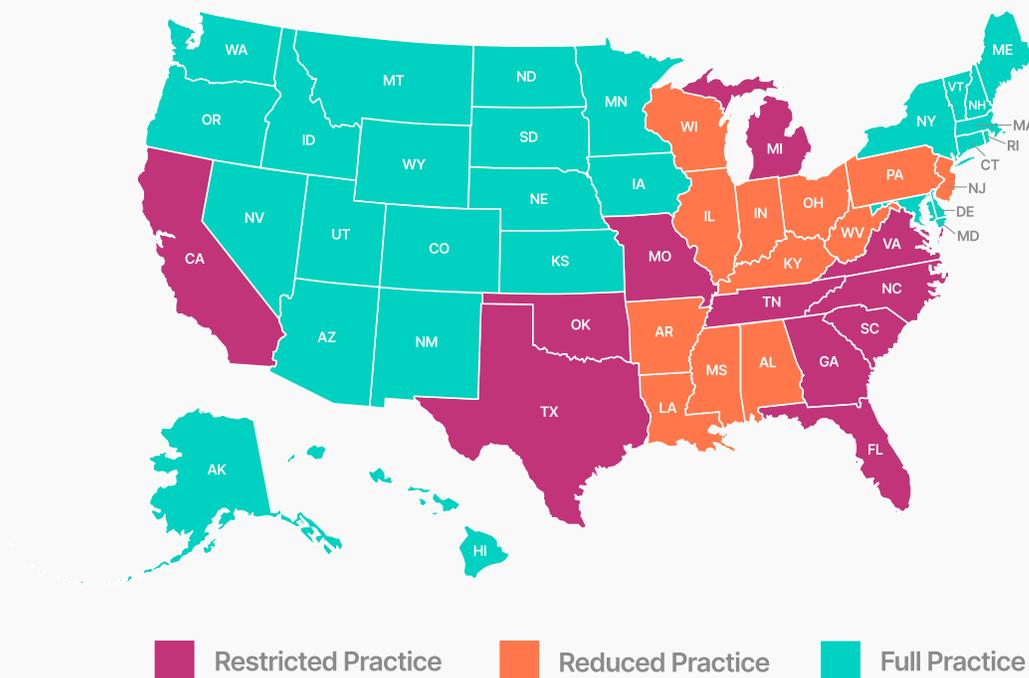
Practice Environment	AANP Definition
Restricted Practice	State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.
Reduced Practice	State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.
Full Practice	State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.



Physician Assistant State Practice Environments



Nurse Practitioner State Practice Environments





Zivian's Regulatory Spectrum

Taken together, NP and PA practice authority categories reveal a regulatory landscape that does not divide neatly into "independent" and "supervised" states. Instead, present-day practice authority is a spectrum of models shaped by varying levels of physician involvement, oversight structure, documentation requirements, and transition pathways.

To provide more clarity, Zivian has developed a Regulatory Spectrum that evaluates physician-APP relationships across three main dimensions: Collaboration Type, Physician Involvement, and Vicarious Liability. Rather than relying solely on whether a state requires collaboration, this framework examines how that collaboration is structured and how it operates in practice.

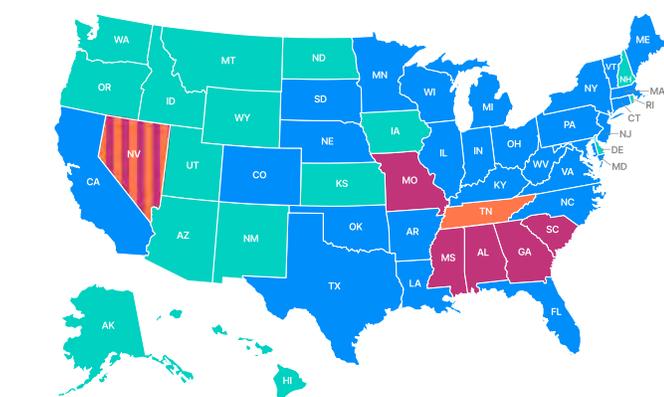
Collaboration Type

This category encompasses the traditional spectrum of relationship types between a physician and an APP. Historically, defining a state's collaboration type has focused on whether a collaboration is required, for how long, and whether the state imposes a geographic restriction on the physician.

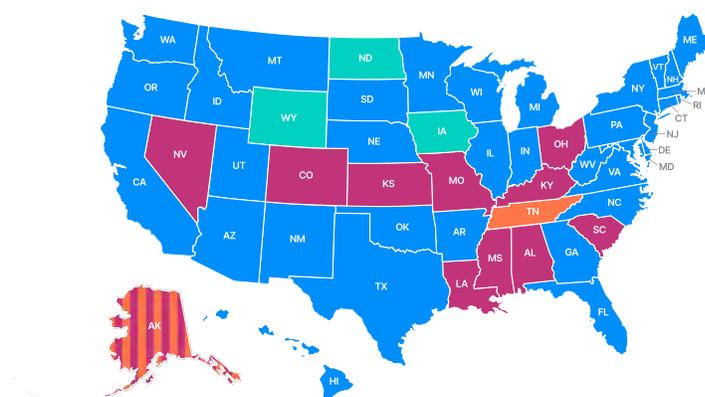
However, Zivian distinguishes within geographic restrictions between a continuous limitation and a sporadic travel requirement, and broadens "transition to independence" to just "transition," which accounts for all changes in collaboration requirements that are tied to the APP's experience.

Collaboration Type	Definition
Geographic Collab	The state imposes a continuous or frequent requirement on where the physician is physically located. For example, the physician must be on-site 10% of the time or the physician must practice within the geographic boundaries of the state.
Travel Requirements	The state imposes a sporadic or infrequent requirement on where the physician is physically located. For example, the physician must be on-site with the APP twice per year.
Remote Collab	No requirements are imposed regarding the physician's physical location.
Independent	The APP may practice independently. If a state requires collaboration in narrow circumstances, the state will be classified as "Independent" with the exception(s) listed.
Transition State	The state imposes heightened requirements when the APP begins practice, but decreases the requirements after a certain number of practice hours or years in practice are met.

Nurse Practitioners



Physician Assistants



■ Independent
 ■ Remote Collab
 ■ Travel Requirements
 ■ Geographic Collab

Note: The maps above reflect pre-transition collaboration types.

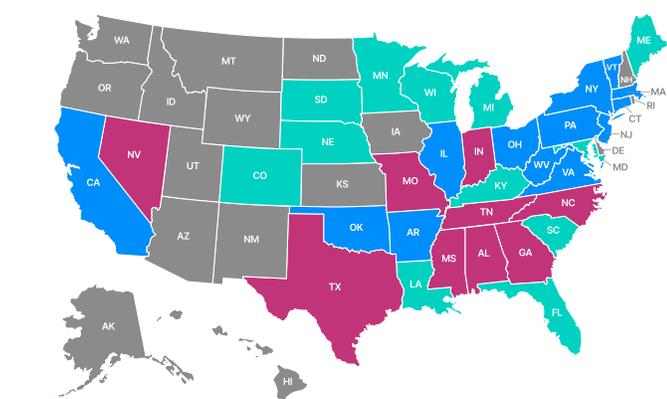
Physician Involvement

This category reflects how much involvement a state requires from the collaborating physician once a physician–APP relationship is in place. In practice, it measures the expected cadence and depth of oversight activities, such as how often the physician must review clinical work, meet with the APP, or participate in quality assurance processes.

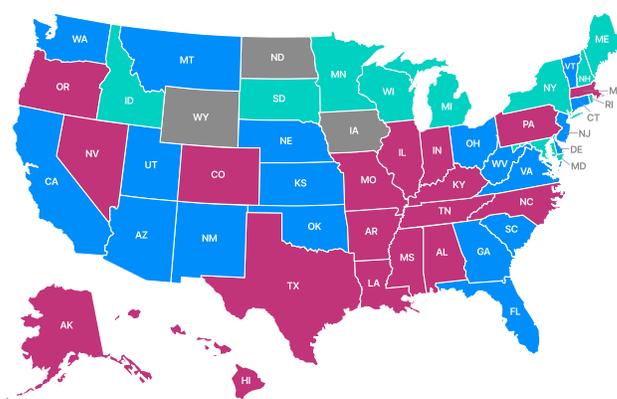
To classify states consistently, Zivian estimated an average level of physician involvement by reviewing collaboration requirements for NPs and PAs nationwide and then compared each state’s rules against that baseline to categorize requirements.

Physician Involvement Classification	Definition
High	The state requires a specific amount of chart review and/or frequent meetings with the APP. States with high physician involvement prescribe above average collaboration requirements. For example, the physician must meet with the APP quarterly or more frequently.
Standard	The state requires collaboration activities, but the requirements are unspecified and/or infrequent. For example, the state requires the physician implement a quality assurance plan, but does not provide guidance on the structure of that quality assurance plan.
Low	The APP must have a collaborating physician, but the state does not require any chart review or meetings.
N/A	Physician Involvement does not apply, as the state allows independent practice or does not have formal oversight requirements.

Nurse Practitioners



Physician Assistants



Vicarious Liability

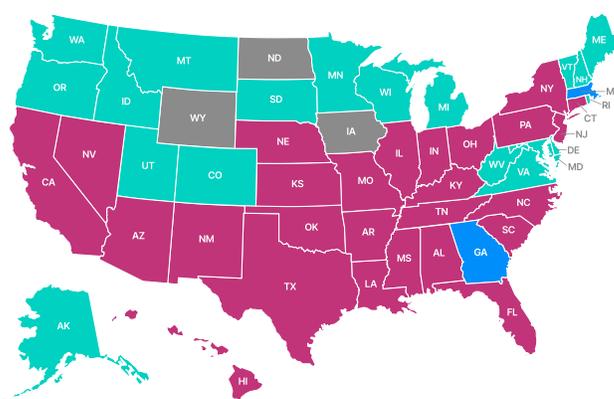
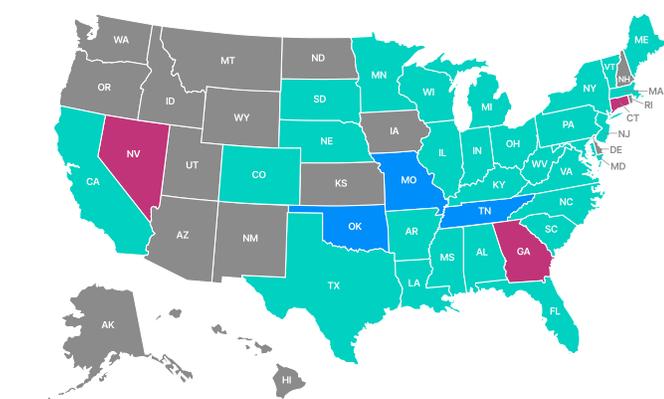
This category indicates whether a collaborating physician is legally responsible for the acts or omissions of an APP solely because of the collaboration relationship.

In states that impose vicarious liability, the law treats the APP as acting on behalf of the physician, meaning the physician may be held accountable for the APP's clinical actions even without separate fault. In other states, the APP remains independently responsible for his or her own acts, and the physician is not automatically liable based only on the existence of the collaboration.

Vicarious Liability Classification	Definition
Yes	The physician is liable for all acts and omissions of the APP under the collaboration.
No	The state either remains silent or explicitly clarifies that the APP is responsible for his or her own acts and that the physician will not be liable without separate fault.
Prescribing Only	The state explicitly makes physicians liable for the APP's prescriptive practice. This is most common in states that only require collaboration if the APP is prescribing.

Nurse Practitioners

Physician Assistants



N/A
 Yes
 No
 Prescribing Only

Spotlight: Transition States

In “transition to independence” states, APPs in full practice authority pathways may still need a defined period of compliant collaboration before practicing independently. During this phase, the APP must maintain an approved physician relationship and complete oversight activities required by state law. Transition thresholds are usually tied to years of experience or a set number of documented clinical hours, and states may require verification of hours before independence is officially granted.

In other “transition” states, the APP never reaches full independence. Collaboration remains a standing requirement throughout the APP’s career, but the structure and intensity of oversight decrease once the APP meets an experience threshold. Requirements may loosen over time while still requiring a collaborating physician.

Critical Factors in Transition-to-Independence



Additional Requirements
CE, letters of recommendation, affidavits, formal application to state board.



Performance Evaluation
Even after meeting thresholds, scope limitations may require collaboration.



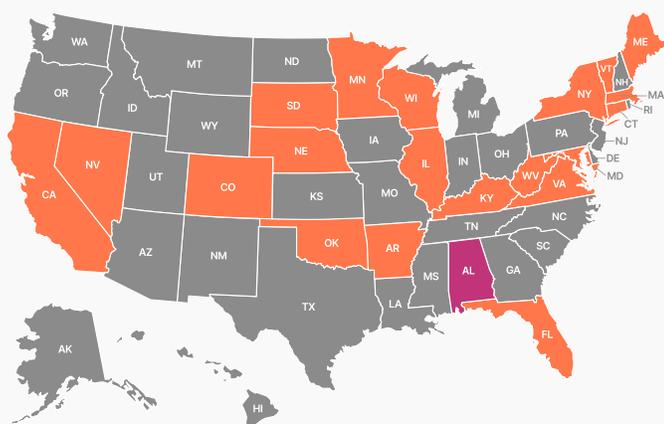
Board Submission Processing
Application to state board. Processing time can take months.



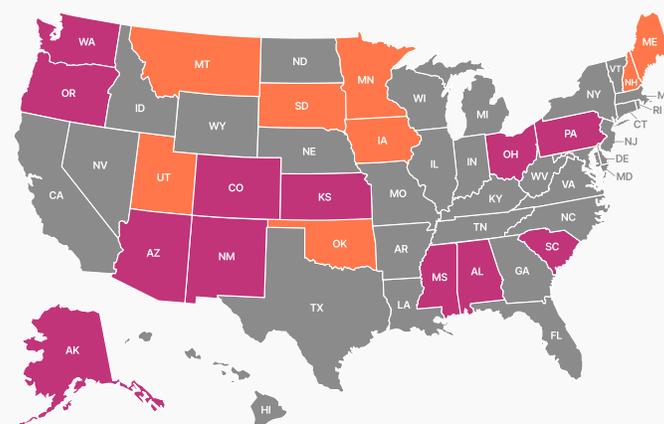
Experience Thresholds
States mandate clinical hours (e.g., 3,600). Some states accept experience from any state.

Transition States: NPs and PAs

Nurse Practitioners



Physician Assistants



Transition Transition to Independence



Collaboration Agreements in Practice

In states that require collaboration or supervision, a written agreement defines the working relationship between an APP and a physician.

This agreement puts into writing how the two clinicians will work together under state law.

At its most basic level, collaboration agreements exist because state law requires an APP to have a formal physician relationship as a condition of providing clinical services. The agreement explains how clinical authority is shared, how the physician will be involved, and how oversight will take place. It turns legal requirements into a clear description of how care will be delivered in practice.

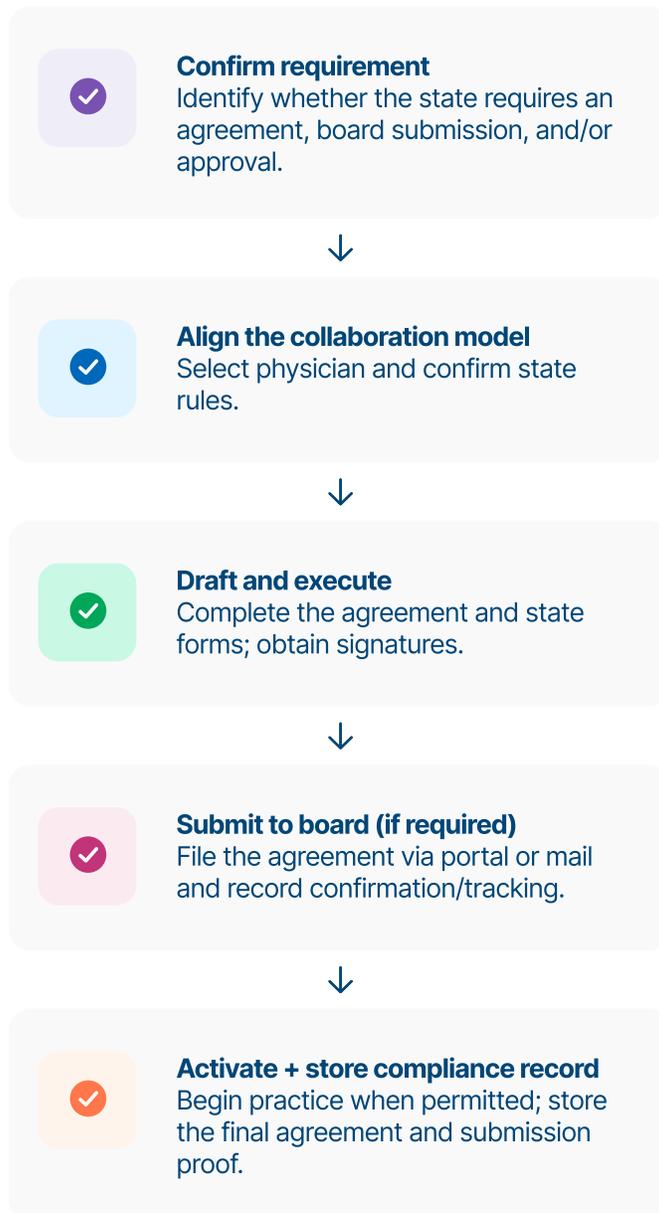
The Role of a Collaboration Agreement

The role of a collaboration agreement varies by state. In some states, the agreement only needs to be signed and kept on file. In others, it must be submitted to a licensing board, and a few states require board review or approval before an APP may begin practicing. Filing rules, renewal expectations, and reporting requirements also differ, which requires coordination across clinical leadership, credentialing, compliance, and legal teams, especially for multi-state organizations.

Even with these differences, most collaboration agreements cover similar core topics. They identify the APP and physician, define scope of services, describe what prescribing is allowed, and outline physician availability and how oversight will be documented. In states with ratio limits or practice site restrictions, those requirements are typically included as well. Agreements may also need updates when an APP changes specialties, adds a new practice location, expands prescribing authority, or changes collaborating physicians.

In this way, the agreement serves as a living record of how the physician–APP relationship is structured over time, and keeping that record organized supports consistent operations and compliance.

Collaboration Agreement Board Submission Breakdown



The following table outlines the core components most commonly required in collaborative practice agreements across the U.S.

Components of a Collaboration Agreement

Required Component	Definition
Collaborating Physician	The agreement must name the physician responsible for collaboration.
Collaborating APP	The agreement must clearly identify the NP or PA covered by the collaboration.
Scope of Practice	Defines what clinical services the APP is authorized to provide under the agreement.
Prescriptive Authority	Specifies what medications the APP may prescribe, including any limits, controlled substances, or schedules of medication.
Physician Availability	Describes how and when the physician must be available for consultation (e.g., phone, telehealth, in person).
Chart Review Requirements	Outlines if charts must be reviewed, how often, and what percentage of cases are reviewed.
Quality Assurance Process	Defines how clinical quality is monitored (e.g., audits, performance reviews, case discussions).
Meeting Requirements	Specifies required meetings between the APP and physician (frequency, format, documentation).
Practice Locations	Lists approved practice sites or confirms whether remote/telehealth practice is allowed.
Backup or Covering Physician	Identifies an alternate physician if the primary collaborator is unavailable.
Emergency & Escalation Protocols	Describes how complex or emergency cases are escalated to a physician.
Documentation & Record Retention	Specifies how long collaboration records, reviews, and attestations must be kept.
Agreement Review & Updates	Defines how often the agreement must be reviewed or updated (e.g., annually or upon scope change).
Effective Date & Termination	States when the agreement begins and how it may be ended or modified.
Signatures	Requires signatures from both the APP and collaborating physician to be valid.



Ongoing Collaboration Compliance

A collaboration agreement is only the first step in collaboration compliance.

Once an agreement is in place—and where required, submitted or approved—most states impose ongoing requirements that govern how that relationship functions over time.

Together, these ongoing requirements form the day-to-day compliance responsibilities that follow a collaboration agreement. Collaboration compliance consists of the structured oversight and documentation activities that extend beyond the initial agreement. Typically, where physician involvement is required as a condition of practice, that involvement must be actively maintained and recorded on an ongoing basis.

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Understanding Ongoing Collaboration Compliance

Ongoing collaboration compliance is a set of recurring oversight and documentation tasks required after a collaboration agreement is executed and, where required, submitted or approved. These obligations follow set timelines and are meant to show that physician involvement is maintained as required under state rules.

Because this work repeats and spans multiple teams, organizations benefit from clear ownership and centralized tracking for oversight activities and updating agreements as practice evolves. As APP teams grow or operate across states, coordination across clinical, credentialing, operations, and compliance functions helps keep documentation and timelines consistent.

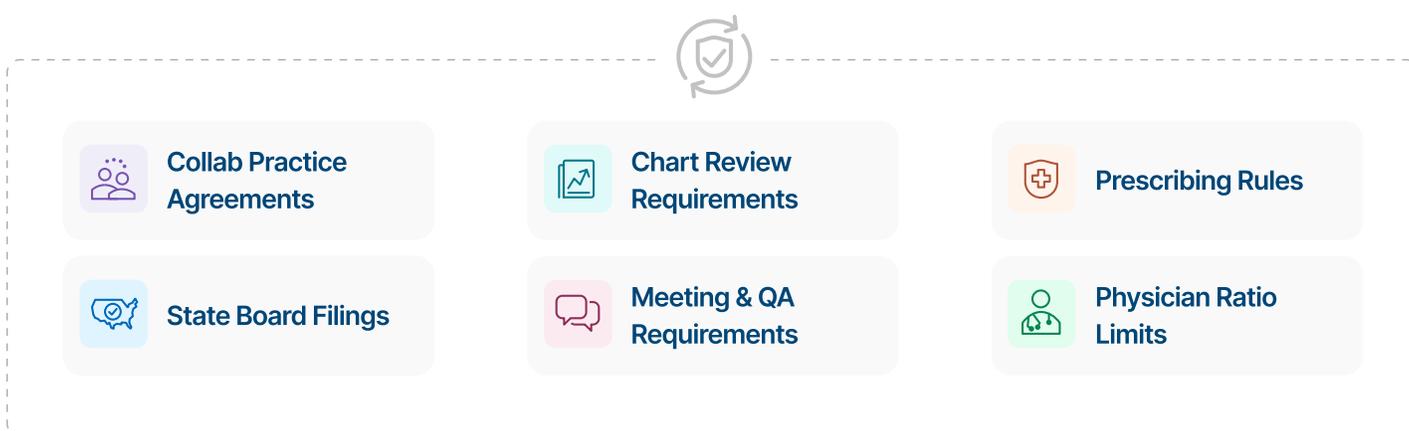
In many states, ongoing collaboration requirements typically include:

- Periodic chart review
- Scheduled meetings between the APP and physician
- Documented quality assurance processes
- Monitoring of physician-to-APP ratios

Some states also require:

- Annual attestations or formal agreement renewals
- Notification when practice sites change
- Updates when prescriptive authority expands
- Documentation when collaborating physicians change

The Lifecycle of Collaboration Compliance



The tables that follow provide a state-by-state overview of ongoing collaboration compliance requirements, highlighting differences in operational difficulty and oversight rules.

NPs: Collaboration Rules by State

	Collaboration Type	Physician Involvement	Chart Review	Meeting Frequency	Vicarious Liability
AL*	Geographic	High	QA Required	Quarterly	✗
AK	Independent	✗	✗	✗	✗
AZ	Independent	✗	✗	✗	✗
AR*	Remote	Standard	QA Required	QA Required	✗
CA*	Remote	Standard	QA Required	QA Required	✗
CO*	Remote	Low	✗	✗	✗
CT*	Remote	Standard	QA Required	QA Required	Implicit
DC	Independent	✗	✗	✗	✗
DE	Independent	✗	✗	✗	✗
FL*	Remote	Low	✗	✗	✗
GA	Geographic	High	Monthly	Annually	✓
HI	Independent	✗	✗	✗	✗
ID	Independent	✗	✗	✗	✗
IL*	Remote	Standard	"Periodically"	Schedule II Only	✗
IN	Remote	High	Weekly	✗	✗
IA	Independent	✗	✗	✗	✗
KS	Independent	✗	✗	✗	✗
KY*	Remote	Low	✗	Controlled Only	✗
LA	Remote	Low	✗	✗	✗
ME*	Remote	Low	✗	✗	✗
MD*	Remote	Low	✗	✗	✗
MA*	Remote	Standard	QA Required	QA Required	✗
MI	Remote	Low	✗	✗	✗
MN*	Remote	Low	✗	✗	✗
MS	Geographic	High	Monthly	Quarterly	✗

***Transition State:** See [NP Transition State Rules](#) for more information on transition requirements and ongoing compliance.

	Collaboration Type	Physician Involvement	Chart Review	Meeting Frequency	Vicarious Liability
MO	Geographic	High	Bi-Weekly	Bi-Weekly	Prescribing Only
MT	Independent	✗	✗	✗	✗
NE*	Remote	Low	✗	✗	✗
NV*	Geographic/Travel	High	Required	QA req. monthly on-site	✓
NH	Independent	✗	✗	✗	✗
NJ	Remote	Standard	"Periodically"	✗	✗
NM	Independent	✗	✗	✗	✗
NY*	Remote	Standard	Quarterly	✗	✗
NC	Remote	High	Monthly	QA Required	✗
ND	Independent	✗	✗	✗	✗
OH	Remote	Standard	Annually	Annually	✗
OK*	Remote	Standard	"Appropriately"	"Regularly"	Prescribing Only
OR	Independent	✗	✗	✗	✗
PA	Remote	Standard	Required	Phys. Must Be Available	✗
RI	Independent	✗	✗	✗	✗
SC	Geo	Low	✗	✗	✓
SD*	Remote	Low	✗	✗	✗
TN	Travel	High	Monthly	Monthly	Prescribing Only
TX	Remote	High	Required	Monthly	✗
UT	Independent	✗	✗	✗	✗
VT*	Remote	Standard	QA Required	QA Required	✗
VA*	Remote	Standard	Required	✗	✗
WA	Independent	✗	✗	✗	✗
WV*	Remote	Standard	Annually	Annually	✗
WI*	Remote	Low	✗	✗	✗
WY	Independent	✗	✗	✗	✗

***Transition State:** See [NP Transition State Rules](#) for more information on transition requirements and ongoing compliance.

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PA: Collaboration Rules by State

	Collaboration Type	Physician Involvement	Chart Review	Meeting Frequency	Vicarious Liability
AL*	Geo	High	Required	10% On-Site	✓
AK*	Geo	High	Required	Monthly	✗
AZ*	Remote	Standard	QA Required	QA Required	✓
AR	Remote	High	Quarterly	Monthly	✓
CA	Remote	Standard	QA Required	QA Required	✓
CO*	Geographic	High	Biannual	Biannual	✗
CT	Remote	Standard	Required	QA Required	✓
DC	Remote	High	QA Required	Quarterly	✓
DE	Remote	Standard	QA Required	QA Required	✗
FL	Remote	Standard	QA Required	QA Required	✓
GA	Remote	Standard	Periodically	✗	Prescribing Only
HI	Remote	High	Weekly	✗	✓
ID	Remote	Low	None	None	✗
IL	Remote	High	Req.	Monthly	✓
IN	Remote	High	Bi-weekly	None	✓
IA*	Independent	✗	✗	✗	✗
KS*	Geographic	Standard	Periodic, but weekly for first month	QA Required Annually	✓
KY	Geographic	High	"Sufficient Number"	QA Required	✓
LA	Geographic	High	Monthly	Weekly	✓
ME*	Remote	Low	Monthly	Weekly	✓
MD	Remote	Low	✗	✗	✗
MA	Remote	High	Quarterly	Ongoing Direction	Prescribing Only
MI	Remote	Low	✗	✗	✗
MN*	Remote	Low	✗	✗	✗
MS*	Geographic	High	Monthly	Quarterly	✓

***Transition State:** See [PA Transition State Rules](#) for more information on transition requirements and ongoing compliance.

	Collaboration Type	Physician Involvement	Chart Review	Meeting Frequency	Vicarious Liability
MO	Geographic	High	Bi-Weekly	✗	✓
MT*	Remote	Standard*	Req.	QA Required	✗
NE	Remote	Standard	QA Required	QA Required	✓
NV	Geographic	Standard	QA Required	QA Required	✓
NH*	Remote	Low	✗	✗	✗
NJ	Remote	Standard	QA Required	QA Required	✓
NM*	Remote	Standard	QA Required	QA Required	✓
NY	Remote	Low	✗	✗	✓
NC	Remote	High	Monthly	QA Required	✓
ND	Ind.	✗	✗	✗	✗
OH*	Geographic	Standard	Biannually	Required	✓
OK*	Remote	Standard	Required	QA Required	✓
OR*	Remote	High	QA Required	Monthly	✗
PA*	Remote	High	Co-Sign. Required	✗	✓
RI	Remote	Low	✗	✗	✗
SC*	Geographic	Standard	Required	✗	✓
SD*	Remote	Low	✗	✗	✗
TN	Travel	High	Monthly	Monthly	✓
TX	Travel	High	Monthly	Required	✓
UT*	Remote	Standard	QA Required	QA Required	✗
VT	Remote	Standard	QA Required	QA Required	✗
VA	Remote	Standard	QA Required	Required	✗
WA*	Remote	Standard	QA Required	QA Required	✗
WV	Remote	Standard	QA Required	QA Required	✗
WI	Remote	Low	✗	✗	✗
WY	Independent	✗	✗	✗	✗

***Transition State:** See [PA Transition State Rules](#) for more information on transition requirements and ongoing compliance.

NP Transition State Rules

	Collaboration Type	Physician Involvement	Vicarious Liability	Transition to →	Collaboration Type	Physician Involvement	Vicarious Liability
AL	Geographic	High	✗	🕒 4,000 hours	Travel Req.	High	✗
	Notes & Exceptions: Collaborations filed as telehealth only have no in-person requirements.						
AR	Remote	Standard	✗	🕒 6,240 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
CA	Remote	Standard	✗	🕒 4,600 hours	Remote	Low	✗
	Remote	Low	✗	🕒 3 years	Independent	✗	✗
Notes & Exceptions: After 4,600 hours, NPs may work without standardized procedures in a group setting with at least one physician.							
CO	Remote	Low	✗	🕒 750 hours	Independent	✗	✗
	Notes & Exceptions: A collaboration is only required if provisional prescriptive authority is granted.						
CT	Remote	Standard	✓	🕒 2,000 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
FL	Remote	Low	✗	🕒 3,000 hours	Independent	✗	✗
	Notes & Exceptions: Before transition, geographic restriction exists for NPs practicing aesthetics in a medical office. Additionally, independent practice is only allowed for family medicine, general pediatrics, and general internal medicine.						
IL	Remote	Standard	✗	🕒 4,000 hours	Independent	✗	✗
	Notes & Exceptions: N/A						

	Collaboration Type	Physician Involvement	Vicarious Liability	Transition to →	Collaboration Type	Physician Involvement	Vicarious Liability
KY	Remote	Low	✗	🕒 4 years	Independent	✗	✗
	Notes & Exceptions: If NP is prescribing controlled substances, Physician Involvement is "High" for the first year of each collaboration, then "Standard." Additionally, independence for controlled substance prescribing requires four years of experience prescribing controlled substances.						
ME	Remote	Low	✗	🕒 2 years	Independent	✗	✗
	Notes & Exceptions: N/A						
MD	Remote	Low	✗	🕒 18 months	Independent	✗	✗
	Notes & Exceptions: NPs with out of state certifications are not required to have a collaborator, even if the NP has been in practice for less than 18 months.						
MA	Remote	Standard	✗	🕒 2 years	Independent	✗	✗
	Notes & Exceptions: A collaboration is required for prescriptive practice only.						
MN	Remote	Low	✓	🕒 2,080 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
NE	Remote	Low	✗	🕒 2,000 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
NV	Geographic	High	✓	🕒 2 years OR 2,000 hours	Independent	✗	✗
	Notes & Exceptions: A collaboration is required for Schedule II prescribing only.						
NY	Remote	Standard	✗	🕒 3,600 hours	Remote	Low	✗
	Notes & Exceptions: Beginning July 1, 2026, NY will no longer allow independent practice of NPs. NPs must maintain collaborative relationships.						

	Collaboration Type	Physician Involvement	Vicarious Liability	Transition to →	Collaboration Type	Physician Involvement	Vicarious Liability
OK	Remote	Standard	Prescribing Only	6,240 hours	Independent	✗	✗
	Notes & Exceptions: A collaboration is required for prescribing only.						
SD	Remote	Low	✗	1,040 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
VT	Remote	Standard	✗	2,400 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
VA	Remote	Standard	✗	5,400 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
WV	Remote	Standard	✗	3 years	Independent	✗	✗
	Notes & Exceptions: A collaboration is required for prescribing only.						
WI	Remote	Low	✓	3,840 hours	Independent	✗	✗
	Notes & Exceptions: Independence can be applied for beginning September 1, 2026.						

PA Transition State Rules

	Collaboration Type	Physician Involvement	Vicarious Liability	Transition to →	Collaboration Type	Physician Involvement	Vicarious Liability
AL	Geographic	High	✓	4,000 hours	Travel	High	✓
	Notes & Exceptions: N/A						
AK	Geographic	High	✗	2 years	Travel	High	✗
	Notes & Exceptions: N/A						
AZ	Remote	Standard	✓	8,000 hours	Remote	Low	✗
	Notes & Exceptions: Before transition, Physician Involvement is "High" for Schedule II and III prescribing. After transition, PAs must continue to "collaborate with, consult with, or refer to" appropriate healthcare professionals. There are no formal requirements, but one or more physicians must be named as responsible for the oversight of the PA.						
CO	Geographic	High	✗	5,000 hours	Geographic	Standard	✗
	Notes & Exceptions: PAs licensed in Colorado prior to August 7, 2023, are not subject to pre-transition requirements. PAs practicing in the ER of a Level I or II trauma center will always have heightened supervision requirements.						
IA	Remote	High	✓	2 years	Independent	✗	✗
	Notes & Exceptions: This is only applicable to PAs practicing under their own PC. Otherwise, PAs are independent.						
KS	Geographic	Standard	✓	80 hours	Remote	Standard	✓
	Notes & Exceptions: During the first 30 days of each collaboration, Physician Involvement is "High" due to weekly chart review requirement.						
ME	Remote	Low	✗	4,000 hours	Independent	✗	✗
	Notes & Exceptions: PAs that are the principal provider of a practice cannot be independent.						

	Collaboration Type	Physician Involvement	Vicarious Liability	Transition to →	Collaboration Type	Physician Involvement	Vicarious Liability
MN	Remote	Low	✗	🕒 4 years	Independent	✗	✗
	Notes & Exceptions: After transition, the practice must maintain a Practice Agreement that is reviewed by a physician.						
MS	Geographic	High	✓	🕒 960 hours	Geographic	High	✓
	Notes & Exceptions: For the first 960 hours, PAs must have on-site supervision. Afterward, the PA may practice within 75 miles of the physician's primary practice site. This 75-mile restriction does not apply for primary care, has direct access to the PA's EMR, and practices 20 hours/week or 80 hours/month within the state of MS (excluding telemedicine).						
MT	Remote	Standard	✗	🕒 8,000 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
NH	Remote	Low	✗	🕒 8,000 hours	Independent	✗	✗
	Notes & Exceptions: Pre-transition, PAs may practice in a setting with other physicians without a collaboration agreement.						
NM	Remote	Standard	✓	🕒 3 years	Remote	Low	✗
	Notes & Exceptions: After transition, a collaboration is still required, but no regulations govern the relationship.						
OH	Geographic	Standard	✓	🕒 500-1,000 hours	Remote	Standard	✓
	Notes & Exceptions: Pre-transition requirements applicable to prescribing only.						
OK	Remote	Standard	✓	🕒 6,240 hours	Independent	✗	✗
	Notes & Exceptions: Pre-transition, Physician Involvement is "High" for Schedule II prescribing. After transition, collaboration is always required for Schedule II prescribing.						
OR	Remote	High	✗	🕒 2,000 hours	Remote	Low	✗
	Notes & Exceptions: Required performance assessments can be done by PA's employer.						

	Collaboration Type	Physician Involvement	Vicarious Liability	Transition to →	Collaboration Type	Physician Involvement	Vicarious Liability
PA	Remote	High	✓	1 year	Remote	Low	✓
	Notes & Exceptions: If collaborating with a DO, Collaboration Type is "Geographic."						
SC	Geographic	Standard	✓	2 years	Remote	Standard	✓
	Notes & Exceptions: Pre-transition, the physician may waive the geographic restrictions, subject to approval by the Board. After transition, waiver of geographic restrictions is no longer subject to Board approval.						
SD	Remote	Low	✗	6,000 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
UT	Remote	Standard	✗	10,000 hours	Independent	✗	✗
	Notes & Exceptions: N/A						
WA	Remote	Standard	✗	4,000 hours	Remote	Low	✗
	Notes & Exceptions: N/A						



Regulatory Watch: Recent and Upcoming Changes

The regulatory landscape governing APP practice is not static.

State legislatures, licensing boards, and medical associations continue to update collaboration and supervision requirements — sometimes expanding autonomy, sometimes tightening it. The entries in the following section reflect recent and upcoming regulatory changes that materially affect how organizations structure physician–APP relationships. Zivian monitors these developments on an ongoing basis.

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Noteworthy Changes for Nurse Practitioners



Georgia

In-State Practice Address Interpretation

The Georgia Composite Medical Board has begun rejecting collaboration agreements that list an out-of-state practice address for the NP. Notably, Georgia statutes and regulations do not explicitly require an NP to maintain an in-state practice address. Existing regulations restrict the physician's location, not the NP's.

The Georgia Board of Nursing has confirmed that state law does not require an in-state NP practice address. The Board of Medicine has also published interpretations reinforcing that geographic restrictions apply to physicians. However, despite outreach seeking clarification, the Board of Medicine has continued its current filing practice.

Impact: Organizations deploying remote or multi-state NPs into Georgia should anticipate potential filing rejections if the NP's listed practice address is outside the state, even though the requirement does not appear in statute.



Mississippi

In-State Practice Address Requirement (Board Position)

The Mississippi Board of Nursing has begun rejecting collaboration agreements that list an out-of-state practice address for the NP.

Mississippi regulations do not expressly require NPs to maintain an in-state practice address. However, Zivian has confirmed the Board's stated position that collaboration agreements submitted without an in-state NP practice address will be rejected.

Impact: Organizations deploying telehealth NPs into Mississippi must ensure an in-state practice address is documented on the collaboration agreement to avoid processing delays.



New York

Elimination of Independent Practice (Effective July 1, 2026)

New York has enacted legislation reversing prior expansion of NP autonomy. Beginning July 1, 2026, NPs who have met the 3,600-hour transition-to-practice threshold will no longer be permitted to practice independently.

Instead, qualifying NPs must maintain a “collaborative relationship” with at least one physician. The relationship will be evidenced through an attestation form maintained at the NP’s practice site.

Impact: Organizations currently relying on independent NP practice in New York must plan for re-implementation of physician collaboration infrastructure prior to July 2026.



New Jersey

Officially Removed COVID Waivers

In January 2026, the New Jersey Governor officially ended the state’s COVID-19 State of Emergency. This officially ended many COVID-era flexibilities, including that NPs may practice without a physician collaborator. The COVID-era flexibilities were already widely considered inapplicable, so many clinics will not need to change operations.

Impact: Most organizations have already returned to New Jersey’s standard collaboration requirements, so the formal end of the COVID waiver is unlikely to require operational changes for most organizations. However, it removes any remaining ambiguity and reinforces that NPs must practice under the state’s physician collaboration framework.



Oklahoma

Independent Practice After 6,240 Hours

Oklahoma now permits NPs to apply for independent practice after completing 6,240 hours of clinical experience. NPs must formally apply through the Oklahoma Board of Nursing. However, even after approval for independent practice, NPs may not prescribe Schedule II controlled substances without a collaboration agreement.

Impact: Oklahoma now functions as a transition-to-independence state with a prescribing carve-out. Organizations must account for continued collaboration requirements if Schedule II prescribing is anticipated.

Additional Collaboration Agreement Requirements

Oklahoma has updated its collaboration agreement template to require:

- Identification of a back-up supervising physician
- Disclosure of supervision fees paid by the NP

The supervision fee disclosure requirement does not apply when the NP's employer pays for supervision.

Impact: Collaboration agreements must be updated to reflect these new template requirements. Organizations using legacy templates should review for compliance.



Wisconsin

Independent Practice Pathway (Effective September 1, 2026)

Beginning September 1, 2026, Wisconsin NPs may apply for independent practice after completing 7,680 total clinical hours.

Up to 3,840 of these hours may include experience as a registered nurse in a clinical setting. Qualifying experience may be earned out of state and prior to the law's effective date.

Impact: Wisconsin, previously a “transition state” with collaboration rules required throughout the career of an NP, will become a “transition-to-independence” state. Organizations should anticipate future workforce flexibility beginning in late 2026.

Noteworthy Changes for Physician Assistants



California

Physician Ratio Limit Increased to 8:1

California has increased the number of PAs a physician may collaborate with. Under the updated rule, a physician may now collaborate with up to 8 PAs at once. This replaces the previous 4:1 ratio limit, which allowed an 8:1 exception only for home health PAs.

Impact: This change expands physician capacity and may make it easier for organizations to deploy larger PA teams within a single collaboration structure.



North Carolina

Transition Pathway for Experienced PAs (Effective June 30, 2026, or Upon Rule Adoption)

North Carolina has enacted a transition framework that will reduce formal collaboration requirements for experienced PAs. Starting no later than June 30, 2026, PAs with 4,000 hours or more of practice experience will be eligible to practice without a collaboration agreement when working in a “team-based setting.”

Importantly, North Carolina’s definition of a team-based setting requires physician ownership and operation of the clinic. As a result, while the state is reducing the administrative requirement of maintaining a written collaboration agreement for qualifying PAs, post-transition practice may continue to require physician oversight in practice.

The North Carolina Medical Board is required to adopt rules governing the transition process and may further define or limit the scope of post-transition PA practice. The law takes effect on June 30, 2026, or upon adoption of the required Board rules, whichever occurs first.

Impact: Organizations should monitor North Carolina Board updates closely. Even if collaboration agreements become unnecessary for eligible PAs, physician ownership requirements pending rule changes may continue to shape compliance requirements.



Oklahoma

Independent Practice After 6,240 Hours

Oklahoma now permits PAs to apply for independent practice after completing 6,240 hours of clinical experience. Applications are submitted through the Oklahoma Board of Medicine.

However, Schedule II prescribing authority continues to require a collaboration agreement, even for independently approved PAs.

Impact: Similar to NPs, Oklahoma PAs previously operated under a “transition state” model. Organizations can now expect more workforce flexibility for PAs — however, Schedule II prescribing still requires a collaboration agreement even after independent practice approval.



Pennsylvania

Removal of Geographic Restrictions (MD Collaborations)

The Pennsylvania Board of Medicine has adopted a rule amendment eliminating prior “satellite location” requirements for PA–MD collaborations. Previously, supervising physicians were required to visit satellite practice locations at least once every ten days.

The amendment removes geographic proximity requirements for PA collaborations with MDs. As a result, PA–MD relationships in Pennsylvania now function as remote collaborations without mandated in-person visit frequency.

However, Pennsylvania remains a geographic collaboration state for PA–DO relationships. The Pennsylvania Board of Osteopathic Medicine continues to require weekly on-site visits by the collaborating DO at satellite locations.

Impact: Organizations employing PAs in Pennsylvania must account for different requirements between MD and DO collaborations when structuring oversight.



South Dakota

Independent Practice After 6,000 Hours

South Dakota now permits PAs to practice independently after completing 6,000 hours of clinical experience.

To qualify, PAs must submit an affidavit and documentation of completed hours through the state's online portal.

Impact: South Dakota has transitioned to independent PA practice, reducing long-term physician oversight requirements. Organizations can expect more workforce flexibility for PAs.



Tennessee

Transition Model Under Development

Tennessee has enacted legislation creating a transition pathway for PAs after 6,000 hours of practice. A task force has been established to promulgate implementing regulations.

The statute provides that physician involvement will decrease after the transition threshold is met, but collaboration will remain required for controlled substance prescribing. Specific requirements governing post-transition physician involvement are pending rulemaking.

Impact: Tennessee is updating its transition model, but operational parameters remain undefined. Organizations should monitor forthcoming regulatory guidance before adjusting workforce models.



Historical Context & The Road Ahead

Today's regulatory environment reflects decades of layered reform.

Understanding its origins helps explain why the landscape is fragmented, and why reform continues to move unevenly across states.

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Origins of the NP and PA Professions

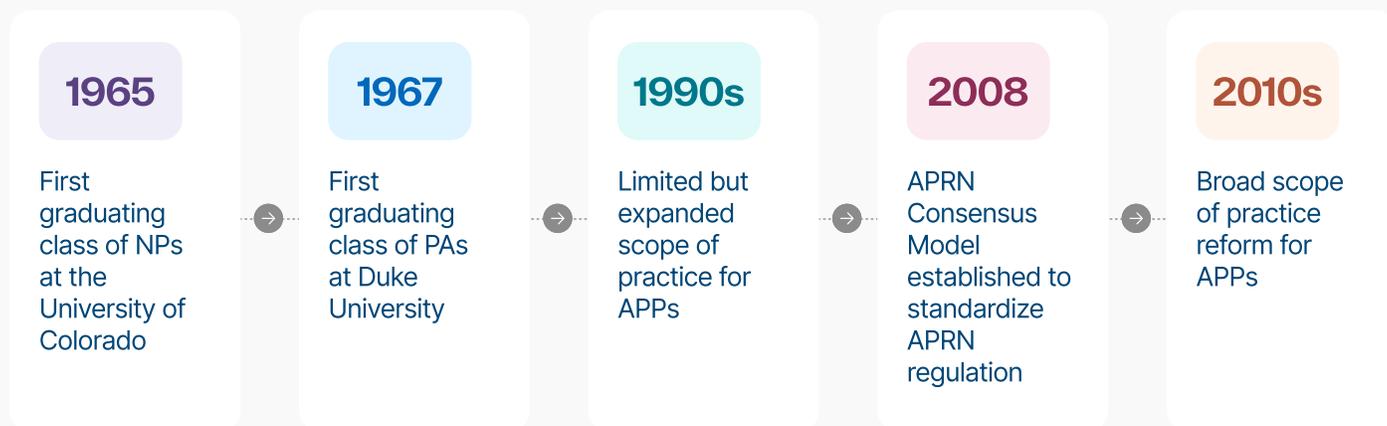
In the mid 1960s, the United States faced a significant shortage of primary care physicians, driven by population growth, uneven physician distribution, expanding demand for frontline care, and an increasing focus on subspecialty training. Many communities, particularly rural and underserved areas, lacked reliable access to care. The NP and PA professions emerged in response to these circumstances.

To address these gaps, healthcare leaders created new clinical pathways that built on existing nursing and medical training while aiming to maintain patient safety and care quality. NPs were first introduced in 1965 through the work of Loretta Ford and Henry Silver at the University of Colorado. Their goal was to expand access to pediatric care by equipping experienced nurses with advanced clinical skills.

The NP role grew quickly, especially in community health and public health settings where nursing's preventive and holistic approach aligned closely with primary care needs. Early NP practice often emphasized collaboration with physicians, both to support clinical development and to align with the regulatory and institutional expectations that shaped the profession as it evolved.

PAs followed soon after, with the first graduating class at Duke University in 1967. The PA profession was designed to quickly expand the medical workforce, drawing heavily from military medics returning from Vietnam. From the outset, PAs were intended to practice as part of physician led teams, with supervision built into their role.

Key Milestones in APP Practice Authority



The Development of Regulatory Frameworks

As both professions matured, state legislatures and licensing boards began developing regulatory frameworks to govern their practice. Because NPs and PAs did not fit neatly within existing medical or nursing statutes, most states developed regulatory models that tied APP practice to some form of physician relationship, whether through supervision, collaboration, delegation, or other oversight mechanisms. These structures were designed to protect patient safety while gradually expanding APP responsibility. Over time, these requirements became state law.

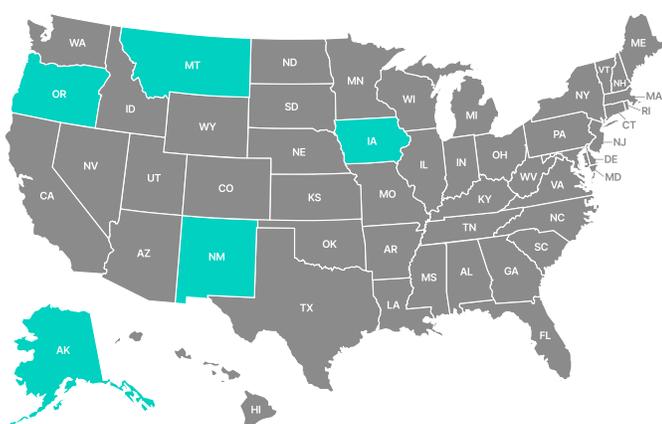
For NPs, physician involvement often took the form of collaborative practice agreements, standardized procedures, delegated prescriptive authority arrangements, or other state-defined oversight mechanisms. In many states, collaboration served as a transitional model between nursing autonomy and the oversight historically required by medical boards.

PAs, regulated primarily by medical boards, were placed under formal supervision models that reflected their medical training and the original intent of supporting physician-led care teams.

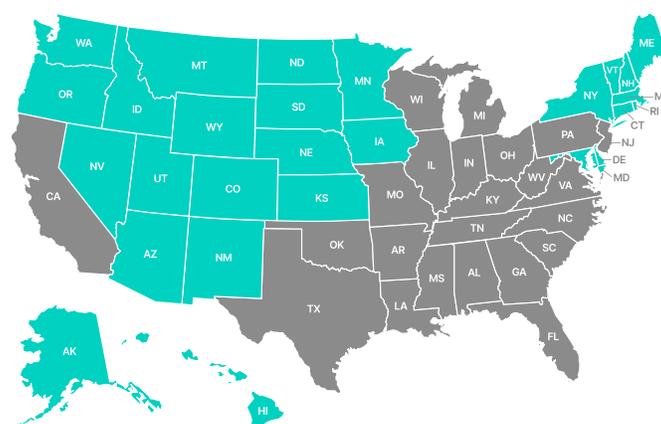
During the 1980s and 1990s, most states expanded APP scopes of practice. NPs gained broader prescriptive authority. PAs gained broader delegated responsibility and often practiced with greater day-to-day independence in hospital and acute care settings, even as formal physician supervision remained the legal framework in most states. Despite these changes, the underlying regulatory distinctions remained. By the early 2000s, most states still required some form of physician collaboration, supervision, delegation, or prescriptive oversight for APP practice.

Then and Now: Independent Practice States for Nurse Practitioners

1994



2026



 Full Practice

Recent Reform and the Current Moment

Over the past two decades, growing workforce shortages have accelerated legislative reform. Full practice authority for NPs has become a major trend and is now adopted in more than half of U.S. states. These laws recognize the advanced nursing model as capable of supporting independent practice, often after a defined transition period that mirrors earlier collaborative frameworks.

PAs have followed a related but distinct path, moving away from strict supervision toward collaborative or delegated practice models. Many states have reduced or eliminated requirements for on site supervision, fixed ratios, or highly prescriptive supervisory contracts.

The result of this long history is a regulatory landscape that reflects layered reform rather than a single, consistent model. In many states, older collaboration and supervision rules remain in place alongside newer pathways that expand autonomy over time. Transition-to-independence requirements add a time-based layer, often requiring documented hours or years of practice before full authority applies.

For organizations deploying APPs today, these laws show up as concrete operational requirements. They shape how quickly clinicians can be activated, what agreements must be executed or filed, how physician involvement must be documented, and what ongoing oversight activities must occur on a recurring schedule.

Managing this well requires clear processes, shared ownership across teams, and infrastructure that can translate decades of regulatory change into compliant operations.



A Note from Griffin Mulcahey, Zivian CEO

At Zivian, we keep seeing the same pattern repeat itself: organizations that are clinically excellent, with real patient demand, that still can't scale because the infrastructure underneath the care model isn't built to carry it.

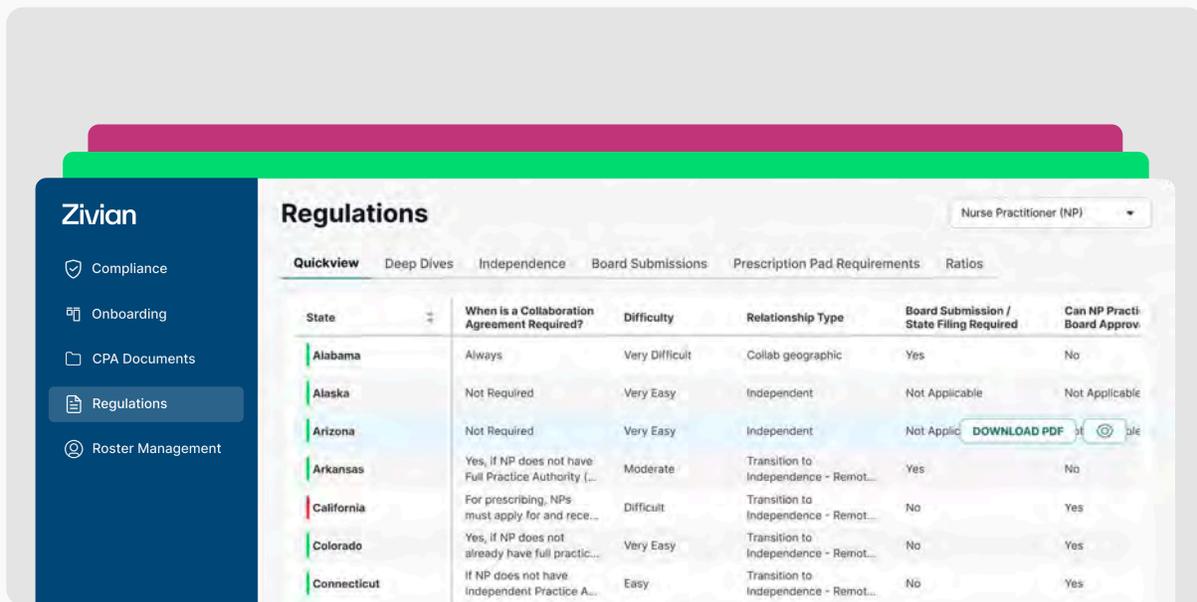
Collaboration law is not the most glamorous corner of healthcare. But in my experience, it's one of the most consequential. The organizations that struggle to scale often aren't failing because of the care they deliver. They're failing because of everything around it. The contracts. The credentialing. The compliance obligations that span every state they operate in, that recur on timelines no one is tracking, that sit across three departments and belong to none of them.

NPs and PAs were introduced to solve a physician shortage that still hasn't closed. The regulatory frameworks built around them were constructed incrementally, over decades, with no single operator in mind. The result is the landscape this report documents: fragmented, state-specific, and operationally demanding in ways that compound as organizations grow.

What we built at Zivian — and what this report reflects — is the belief that clarity is infrastructure. If you can see the regulatory environment clearly, you can build around it. If you can't, you're managing risk you don't fully understand.

We hope this report is useful. We're here if you want to go deeper.

— **Griffin Mulcahey, CEO, Zivian Health**



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About Zivian Health

Zivian is the operating system for a compliant, connected, and high-performing healthcare workforce.

Our platform helps healthcare enterprises manage the operational complexity of NP and PA collaboration law — including agreement execution, ongoing compliance tracking, and regulatory monitoring — across every state they operate in.

By translating nuanced regulations into structured workflows and centralized visibility, we enable organizations to activate clinicians faster, maintain consistent oversight, and manage ongoing requirements at scale.

To learn more, visit zivianhealth.com or [schedule a demo here](#).

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