**L**ouisiana **S**tate **B**oard of **M**edical **E**xaminers

630 Camp Street, New Orleans, LA 70130

504 568 6820

Collaborating Physician Recommendation

Date

To Physician Name:

Street Address:

City:

State:

Zip:

Telephone:

Re Medical Psychologist Name:

Street Address:

City:

State:

Zip:

Telephone:

Email:

LSBEP License number:

The referenced medical psychologist hasapplied to the Louisiana State Board of Medical Examiners for a Certificate of Advanced Practice in accordance with Act 251 of the 2009 session of the Louisiana Legislature which transferred the regulation of medical psychology to the Louisiana State Board of Medical Examiners and provided for the issuance of such certificates.

The recommendation of two collaborating physicians, each of whom holds an unconditional license to practice medicine in Louisiana, and who are familiar with his or her competence to practice medical psychology is required for a certificate of advanced practice. He or she has asked that you provide such a recommendation.

"Medical psychology" means that profession of the health sciences which deals with the examination, diagnosis, psychological, pharmacologic and other somatic treatment and/or management of mental, nervous, emotional, behavioral, substance abuse or cognitive disorders, and specifically includes the authority to administer, distribute without charge and/or prescribe drugs as defined in this Part. In addition, the practice of medical psychology includes those practices defined in R.S. 37:2352(5).

Please complete this form and return directly to LSBME

US Mail LSBME, 630 Camp Street, New Orleans, LA 70130

Fax (504) 599-0503

Email [licensing@lsbme.la.gov](mailto:licensing@lsbme.la.gov)

I certify that I hold an unrestricted license to practice medicine in Louisiana and have collaborated with the named medical psychologist and hereby attest to his or her competence to practice medical psychology as defined above.

Signed (no stamps) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical License number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_