COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

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FORM B
ADVANCED PRACTICE REGISTERED NURSE (APRN)
NURSE PROTOCOL AGREEMENT
TERMINATION NOTIFICATION FORM

ONLY COMPLETE this form if you are terminating from an APRN you are currently supervising.

360-32-.05 (5) A delegating physician shall notify the Georgia Medical Board within ten (10) working days of the date of termination of a nurse protocol agreement with the delegating physician and APRN.

Delegating Physician Statement:

I hereby serve notice to the *Composite State Board of Medical Examiners* that I have

submitted my termination with APRN ____
(APRN Full Name) – please print legibly

________________________effective:_________/_________/_________.
(license number) (Month) (Day) (Year)

____ ________________________
Delegating Physician Name – (please print legibly) License Number

____ ________________________
Delegating Physician Signature Date Signed

This termination includes all, if any, other designated physicians approved for this APRN under my request.

APRN Statement:

I hereby serve notice to the *Composite State Board of Medical Examiners* that I have

accepted the termination of ____
(Delegating Physician Full Name)– please print legibly

effective:_________/_________/_________.
(Month) (Day) (Year)

____ ________________________
APRN Signature Date Signed