GEORGIA COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

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http://www.medicalboard.georgia.gov

E-Mail: Medbd@dch.ga.gov

ADVANCED PRACTICE REGISTERED NURSE (APRN) PROTOCOL AGREEMENTS
GENERAL INFORMATION

REGISTRATION FORMS WILL NOT BE REVIEWED WITHOUT REGISTRATION FEE

Registration Fee: $50.00;

Make check/money order payable to: **CSBME**

NOTE: THE FEE MAY BE WAIVED FOR THE PROTOCOL APPLICANT IF THE APPLICANT'S PHYSICIAN IS AN EMPLOYEE OF THE STATE OF GEORGIA, OR A COUNTY OR CITY IN GEORGIA. PLEASE SUBMIT EVIDENCE OF EMPLOYMENT, SUCH AS A W2.

Please read all materials and instructions carefully. In order for your protocol to go before the Georgia Medical Board for review, it must be received as "completed" 15 business days before the next monthly board meeting. Your form is complete when all primary source documentation has been received. It is imperative for applicants to understand that the review process is guided by the requirements set forth in State law, which does not provide for any waivers to be granted by staff.

Physician Address Information

Use your office address as your address of record. Georgia law requires that the Georgia Medical Board be kept informed of any changes of address. Changes should be submitted in writing to the above address, and should include the license number, name, old address and new address.

ADVANCED PRACTICE REGISTERED NURSE (APRN) PROTOCOL AGREEMENT - CHECKLIST

The CHECKLIST is intended to assist you with the filing of a complete Nurse Protocol Agreement to the Georgia Medical Board. Read all instructions on each page carefully and utilize the checklist as you are filling out the form. All items listed that apply to your situation must be submitted. When submitting copies of documents, please ensure they **are 8-1/2 x11-inch copies** of the original. *Do not submit two-sided copies of the form or documentation*. **For quality and confidential purposes, facsimiles of form materials are not accepted. All form material must be original, unaltered, and official where required.**

DELAGATING SUPERVISING PHYSICIAN REQUIREMENTS

Prior to submitting a Nurse Protocol Agreement, the delegating physician should review the requirements below:

- ☐ **A physician whose medical license is restricted** shall not enter **into a nurse protocol agreement, unless** the physician has received **prior** written approval from the Georgia Medical Board. If you fall into this category, **you are responsible for providing the Board with a copy of any and all consent orders or actions against your license.**
- ☐ No physician may enter into a nurse protocol agreement with an APRN whose specialty area or field is not comparable to the physician's specialty area or field. **Please make sure your specialty areas are comparable.**
- ☐ Unless specifically exempted by paragraph (g) of Code Section 43-34-26.3, a delegating physician **may not enter** into a nurse protocol agreement with more **than four APRN's at any one time**. Please verify that you have no more than four APRN's at one time.
- ☐ Except for practice settings identified in paragraph (7) of subsection (g) of Code Section 43-34-26.3, a physician **shall not be an employee** of an APRN, alone or in combination with others, if the physician delegates authority to and/or is required to supervise the employing APRN.
- ☐ The Fee **may be waived for the Protocol Agreement if the applicant's physician is an employee of the State of Georgia, or a County or City in Georgia. Proof of employment, such as a copy of a W2 must be attached to the packet in order to waive the fee.**

DOCUMENTATION REQUIREMENTS:

THE NURSE PROTOCOL REGISTRATION PAGE

This page contains the registration information for the Delegating Physician and APRN. Complete all requested information, including license history and signatures.

THE NURSE PROTOCOL AGREEMENT

The requirements to be included in the Nurse Protocol Agreement are found in **Rule 360-32-.02**. Make sure that each requirement has been addressed in the Nurse Protocol Agreement. The Protocol Agreement should be signed and dated by the Delegating Physician, APRN, and all Designated Physicians.

FORM C – NURSE PROTOCOL WORKSHEET

- The Formulary Section should list 20 (and **no more than 20**) of the **most commonly used** medications in you practice. Please list **specific drugs**, **not drug categories**. Please note that you will **not** be limited to these 20 medications in your practice.
- The Routinely Performed Procedures should clearly define which **routine procedures** the Nurse Practitioner will be performing.
- The Protocol Reference Sources are the guidelines that are used in your practice. Guidelines **written specifically for Nurse Practitioners** are recommended, but any guidelines written specifically for your specialty or area of practice will be accepted. This may be any **nationally recognized source** depending on your type of practice. However, **PDR, standard medical reference textbooks, general medical texts, and websites are not applicable**.

Form C must have the **Delegating Physician and APRN signatures and dates**.

NURSING VERIFICATION

- Current verification from the Georgia Board of Nursing
- Documentation of any Disciplinary Actions/ Orders from the Georgia Board of Nursing
- **Documentation/certification for training or qualifications in specialty areas**

FORM A - for Designated Physicians

This page contains the registration information for the Designated Physician. Designated physicians are for **back-up/consulting purposes** in the absence of the Delegating Physician. Complete all requested information, including license history and signature.

REGISTRATION FEE

The registration fee is **$50.00**, payable by check or money order to **CSBME**.

NO additional fees are required for the annual update or for adding other designated physicians.

PLEASE MAIL YOUR COMPLETED REGISTRATION PACKET, REQUIRED DOCUMENTATION AND THE NURSE PROTOCOL AGREEMENT TO THE ADDRESS LISTED ON PAGE 1.

ATTACH CHECK	GEORGIA MEDICAL BOARD (GMB) USE ONLY		
	DATE RECEIVED ________________	DATE COMPLETED ________________	

ALL FEES ARE NONREFUNDABLE*

FEES ARE SUBJECT TO CHANGE

DELEGATING PHYSICIAN
ADVANCED PRACTICE REGISTERED NURSE (APRN) PROTOCOL AGREEMENT INFORMATION

DELEGATING PHYSICIAN INFORMATION

LAST NAME	**FIRST NAME**	**MIDDLE NAME**	DEGREE: (MD OR DO)

GEORGIA LICENSE NUMBER ____________________ DEA REGISTRATION NUMBER ____________________	**Please check, if any apply.** **Are you a:** **____Georgia state employee** **____Georgia county employee** **____Georgia city employee** **If you checked any of the boxes above, please submit proof of employment, e.g. W2, 1099, paycheck stub**	PRACTICE DESCRIPTION: ____________________ # OF LOCATIONS (TO INCLUDE SATELLITE SITE(S): ____________________ SPECIALTY AREA:____________________

PRACTICE ADDRESS:			
STREET NUMBER	STREET NAME		SUITE #
CITY	STATE	ZIP CODE	COUNTY
( )	( )		@
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		E-MAIL ADDRESS (REQUIRED)

ADVANCED PRACTICE REGISTERED NURSE (APRN) INFORMATION

RN#:______________________________ **Area of certification:** ☐ **Nurse Practitioner** ☐ **Certified Nurse Midwife** ☐ **Psychiatric/Mental Health Specialist**			**DEA REGISTRATION** **#:**____________________
LAST NAME	**FIRST NAME**	**MIDDLE**	E-MAIL ADDRESS (REQUIRED)

LICENSE HISTORY

Delegating Physician	**Advanced Practice Registered Nurse (APRN)**
INSTRUCTIONS: PLEASE INDICATE YOUR CURRENT LICENSE STATUS.	
DATES OF LICENSURE: (MM/DD/YY TO MM/DD/YY)	DATES OF LICENSURE: (MM/DD/YY TO MM/DD/YY)
ANY RESTRICTIONS ON CURRENT GA LICENSE:	ANY RESTRICTIONS ON CURRENT APRN LICENSE:
CURRENT STATUS OF LICENSE:	CURRENT STATUS OF LICENSE:

The undersigned acknowledges having read and understood Rule 360-32 “Nurse Protocol Agreements Pursuant to OCGA 43-34-26.3.”

________________________________ ____________________

DELEGATING PHYSICIAN SIGNATURE DATE

________________________________ ____________________

APRN SIGNATURE DATE