

FORM C
APRN PROTOCOL WORKSHEET

PLEASE PRINT LEGIBLY

DELEGATING PHY NAME: _____ **LICENSE#:** _____

APRN NAME: _____ **RN#:** _____

ADDRESS: _____ **Phone#:** _____

CERTIFICATION INFORMATION: (PLEASE CHECK THE APPROPRIATE BOX)

- CERTIFIED NURSE MIDWIFE PSYCHIATRIC/MENTAL HEALTH SPECIALIST
 NURSE PRACTITIONER

Procedures being performed by the APRN are within competency of their certification specialty.

OR

Procedures being performed by the APRN that are not within competency of their certification specialty are listed below:

(Please provide documentation of training and competency for each procedure- see instructions)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

If the authority to prescribe controlled substances has been delegated to the NP under this agreement, we acknowledge that by law the APRN is not authorized to prescribe Schedule I controlled substances as defined in O.C.G.A. § 16-13-25 or Schedule II controlled substances as defined in O.C.G.A. §16-13-26.

APRN SIGNATURE

DATE

PHYSICIAN SIGNATURE

DATE

FORM C – INSTRUCTIONS FOR COMPLETION

(must include the **Delegating Physician and APRN signatures and dates**)

ILLEGIBLE FORMS ARE NOT ACCEPTED

***FOR ANY MEDICAL PROCEDURES PERFORMED WHICH ARE OUTSIDE THE NORMAL SCOPE OF PRACTICE FOR THE NURSE PRACTITIONER (BASED ON CERTIFICATION SPECIALTY), documentation of competency is required.** Some of these procedures are chest tubes, central lines, arterial lines, intubations, joint aspirations and injections (specify joint/s,) trigger point injections, stress test, implanted birth control, colposcopy, thoracentesis, bronchoscopy, lumbar puncture, bone marrow biopsy, etc. The additional documentation should include the following for EACH MEDICAL PROCEDURE:

- Number of times the delegating physician has supervised this procedure being performed by the APRN (minimum of 10)
- Number of times this procedure has been performed by the APRN without supervision (minimum of 10)
- Any other training the APRN has received for this procedure (such as school curriculum or at a previous medical practice)
- Patient outcomes, including any complications
- Time frame in which the on-the-job training occurred
- Signature and date of the delegating physician

IF ON-THE-JOB TRAINING HAS NOT BEEN COMPLETED, PER THE GUIDELINES GIVEN, PLEASE REMOVE THE PROCEDURE(S) FROM FORM C AND RESUBMIT. A NEW FORM C AND TRAINING DOCUMENTATION MAY BE SUBMITTED ONCE THE ON-THE-JOB TRAINING IS COMPLETE.

Please note: This form can be completed using the GCMB website. Type the appropriate information on Form C on-line, print the form, and obtain signatures. Electronic signatures are NOT accepted.