ATTACH CHECK HERE

GEORGIA COMPOSITE MEDICAL BOARD (GCMB) USE ONLY

DATE RECEIVED _____ **DATE COMPLETED** _____

ALL FEES ARE NONREFUNDABLE*

FEES ARE SUBJECT TO CHANGE

DELEGATING PHYSICIAN INFORMATION

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

GEORGIA LICENSE NUMBER _____ DEA REGISTRATION NUMBER _____ **Contact Information:** If you are using a credentialing agency, provide the contact information below. Name_____ Email:_____ Phone Number:_____	**Please check, if the delegating physician is a:** **_____Georgia state employee** **_____Georgia county employee** **_____Georgia city employee** **If you checked any of the boxes above, please submit proof of employment.**	PRACTICE DESCRIPTION AND SPECIALTY AREA: _____ Will you be providing any telemedicine services? _____YES _____NO (5) **Rule 360-3-.07. Practice Through Electronic or Other Such Means** To delegate to a nurse practitioner or to supervise a physician assistant doing telemedicine, the physician must document to the board that that the provision of care by telemedicine is in his or her scope of practice and that the NP or PA has demonstrated competence in the provision of care by telemedicine. # OF LOCATIONS- TO INCLUDE SATELLITE SITE(S):

PRACTICE ADDRESS WHERE APRN IS PRACTICING UNDER THIS PROTOCOL AGREEMENT: **(If more than one location, list the primary practice location for the APRN)**			
STREET NUMBER	STREET NAME		SUITE #
CITY	STATE	ZIP CODE	COUNTY
(AREA CODE) PHONE NUMBER ( )	(AREA CODE) FAX NUMBER (OPTIONAL) ( )		

ADVANCED PRACTICE REGISTERED NURSE (APRN) INFORMATION

RN#:_____ **_____ Nurse Practitioner - specify TYPE - Family, Adult, Pediatric, etc._____** **_____ Certified Nurse Midwife** **_____ Clinical Nurse Specialist - Psychiatric/Mental Health** **_____ Clinical Nurse Specialist - OTHER than Psychiatric/Mental Health**	**DEA REGISTRATION #:_____** **(IF ALREADY ISSUED)** _____ CHECK HERE IF PENDING OR WILL APPLY LATER
LAST NAME **FIRST NAME** **MIDDLE**	

LICENSE HISTORY

Delegating Physician	**Advanced Practice Registered Nurse (APRN)**
CURRENT LICENSE EXPIRATION DATE: (MM/DD/YY)	CURRENT LICENSE EXPIRATION DATE: (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 43-34-25."

_____ _____ _____

DELEGATING PHYSICIAN SIGNATURE **E-MAIL ADDRESS (REQUIRED)** DATE

_____ _____ _____

APRN SIGNATURE **E-MAIL ADDRESS (REQUIRED)** DATE