APRN APPLICATION CHECKLIST
HOW TO GET YOUR FILE REVIEWED THE FIRST TIME!!

IF APPLICATION IS INCOMPLETE, YOU WILL BE NOTIFIED VIA EMAIL. IF REQUESTED INFORMATION IS NOT SUBMITTED WITHIN 30 DAYS OF NOTIFICATION, YOUR APPLICATION WILL BE CLOSED!!

Please submit a cover letter and/or resume along with the items below to expedite the review of the protocol agreement. Though this is not a requirement, it is highly recommended.

Please send application to:
GCMB, APRN Department, 2 Peachtree Street, N.W., 6th Floor, Atlanta, GA 30303

Your approval letter will be mailed to your delegating physician's primary practice.

____ **Registration Form** (**ORIGINAL or ELECTRONIC** – must be complete and **SIGN** + include **SPECIALTY** of Physician and APRN)

____ **$150 Fee (check or money order made payable to: GCMB)**

___ **License Verification**

- submit copy of current APRN license
- **submit copy of national certification (wallet card, letter, or certification should include expiration date)**
- submit copy of specialty training (if applicable)

____ **Protocol Agreement** (we prefer the board template). **Original or Electronic signatures required**

- **page 1: DATE** and physician **SPECIALTY**
- **page 2:**
  - **DESCRIPTION OF PRACTICE**
  - **PRACTICE LOCATION**
  - **PATIENT POPULATION** (specify age group)
- **page 3: #2** (select appropriate options)
- **page 4:**
  - **LIST** appropriate references for **CLINICAL GUIDELINES** (textbooks +/- online resources)
  - **#3** Telemedicine (select options)
  - **#5** (select option for Radiographic Imaging Test)
  - **#4** Form C (select options)
  - **#7** (select option for Physician Availability)
- **page 5:**
  - **#9** (select option for controlled substances)
  - **#12 (fill in __##__ months)**
  - **#13** (Abortion Drugs)
- **page 6:**
  - **#16** (select option for Professional Drug Samples)
  - **#17** (fill in - select option for Physician Review and Signing of Records)
- **page 8:** (include signatures and dates)

____ **Form A** (must complete ONE for EACH designated physician)
____ **Form B** (complete if you are terminating previous delegating physician)
____ **Form C** (use revision 10/2019)

- select certification
- select a procedure request category (copies of 10 un-supervised/10 supervised cases)

Version: 10/5/2022