APRN APPLICATION CHECKLIST

HOW TO GET YOUR FILE REVIEWED THE FIRST TIME!!

WHEN EMAILING AND MAILING CHECKS TO THE BOARD, ALSO INCLUDE THE APRN FULL NAME AS WELL AS THE DELEGATING PHYSICIAN NAME. IF NOT SUBMITTED WITHIN 30 DAYS OF NOTIFICATION, YOUR APPLICATION WILL BE CLOSED!!

SEND APPLICATION TO:
Email: Dch.aprn@dch.ga.gov

$150 FEE

- **(check or money order made payable to: GCMB)**
- **Check/Money order MUST be sent in with APRN and Delegating Physician name listed.**

- **PHYSICALLY MAIL THE PAYMENT TO:**
  2 Martin Luther King Jr. Drive SE East Tower, 11th Floor
  Atlanta, GA 30334 US

- **DO NOT INCLUDE YOUR REGISTRATION OR PROTOCOL AGREEMENT WITH YOUR CHECK**

LICENSE VERIFICATION

- You **MUST** submit a copy of your **APRN License, National Certification, and Resume/CV**
- **Resume / CV** needs to show nursing education/training, certification, and work/practice history.

PROTOCOL AGREEMENT (we prefer the board template). **Original or Electronic signatures required.**

- **Page 1: Registration Form (ORIGINAL or ELECTRONIC must be complete & SIGN & include SPECIALTY Physician & APRN.)**
- **Page 2: Nurse Protocol Agreement (FILL OUT FORM COMPLETELY.)**
- **Page 3: Description Of Practice (Include Practice Location & Patient Population *Please specify age range*.)**
- **Page 4: Recitals**
  - **APRN Authorities and Parameters (Fill out completely.)**
- **Page 5: APRN Guidelines (MUST have 3 or more guidelines completed.)**
- **Page 6: Documentation Of Drug Orders**
  - **#16 & 17(c) MUST complete.**
- **Page 7: Miscellaneous Matters**
- **Page 8: Statement Of Approval (MUST have Physician and APRN signatures signed and dated)**

- **FORM A** (Must complete ONE for EACH designated physician)
- **FORM B** (Complete if you are terminating previous delegating physician)
- **FORM C** (Must complete a form for **EACH** procedure)
  - Select a procedure request category (copies of 10 un-supervised/10 supervised cases

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