FORM A
DESIGNATED PHYSICIAN INFORMATION
For the Protocol Agreement between

DELEGATING PHYSICIAN Jane Doe **LICENSE #** 000000

APRN John Smith **LICENSE #** 123456

The DESIGNATED Physician CANNOT be the DELEGATING PHYSICIAN!

The designated physician is available for consulting purposes in the ABSENCE of the delegating physician for the protocol agreement indicated above.

DESIGNATED PHYSICIAN INFORMATION			
LAST NAME	**FIRST NAME**	**MIDDLE NAME**	DEGREE: (MD OR DO)
Dinkleburg	James	Mozzarella	MD
GEORGIA LICENSE NUMBER	DEA REGISTRATION NUMBER	**SPECIALTY AREA (must be the SAME as the specialty area of the DELEGATING Physician**:	
987654	JD111111	Internal Medicine	
DESIGNATED PHYSICIAN PRACTICE ADDRESS:			
STREET NUMBER STREET NAME			SUITE #
2 Martin Luther King Jr. Drive SE East Tower			11th Floor
CITY	STATE	ZIP CODE	COUNTY
Atlanta	Georgia	30334 US	Fulton
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		
000-000-0000			

LICENSE HISTORY	
CURRENT LICENSE EXPIRATION DATE:	6/13/2024
CURRENT STATUS OF LICENSE:	Active
ANY RESTRICTIONS ON CURRENT LICENSE:	N/A

360-32-.02(3) (c) Such designation must include the printed name, license number, and signature of the designated physician with an affirmation from the designated physician that he or she has agreed to serve as a designated physician and has reviewed the nurse protocol agreement and concurs with the terms of the agreement.

_____ 6/12/2024

DESIGNATED PHYSICIAN SIGNATURE DATE