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 _____ PHYSICIAN SPECIALTY _____	**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.**	**Contact Information:** If you are using a credentialing agency, provide the contact information below. Name_____ Email:_____ Phone Number:_____

PRACTICE ADDRESS WHERE APRN IS PRACTICING UNDER THIS PROTOCOL AGREEMENT: (If more than one location, list the primary practice location for the APRN)			# OF LOCATIONS- TO INCLUDE SATELLITE SITE(S):
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