FORM B
ADVANCED PRACTICE REGISTERED NURSE (APRN)
NURSE PROTOCOL AGREEMENT
TERMINATION NOTIFICATION FORM

This form should be completed ONLY if the DELEGATING PHYSICIAN is no longer DELEGATING PRESCRIPTIVE AUTHORITY to the APRN.

360-32-.05 (5) A delegating physician shall notify the Georgia Composite Medical Board within ten (10) working days of the date of termination of a nurse protocol agreement with the delegating physician and APRN.

Jane Cheddar Doe — **Delegating Physician Name – (please print legibly)**

000000 — **License Number**

Joe Romano Shmoe — **APRN Name – (please print legibly)**

246810 — **License Number**

The Protocol Agreement between the above named Delegating Physician and APRN

has been TERMINATED on: 06 **(Month)** / 11 **(Day)** / 2024 **(Year)**.

This termination includes all, if any, Designated Physicians listed on the protocol agreement for the delegating physician and APRN.

Delegating Physician Signature

06/11/2024 — **Date Signed**

APRN Signature

06/11/2024 — **Date Signed**

Both signatures are requested – however, this form will be accepted with only one signature.

Provide a contact name, phone number, and email address should the GCMB need to contact you regarding the information on this form:

Jane Cheddar Doe — **Contact Name**

000-000-0000 — **Phone number**

medbd@dch.ga.gov — **E-mail Address**