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.

_____ _____
Delegating Physician Name – (please print legibly) **License Number**

_____ _____
APRN Name – (please print legibly) **License Number**

The Protocol Agreement between the above named Delegating Physician and APRN

has been TERMINATED on:_____/_____/_____.
(Month) (Day) (Year)

This termination includes all, if any, Designated Physicians listed on the protocol agreement for the delegating physician and APRN.
DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

_____ _____
Delegating Physician Signature **Date Signed**

_____ _____
APRN Signature **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:

_____ _____
Contact Name **Phone number**

_____
E-mail Address