FORM C
APRN PROTOCOL WORKSHEET

PLEASE PRINT LEGIBLY

DELEGATING PHY NAME: _____ **LICENSE#:** _____

APRN NAME: _____ **RN#:** _____

ADDRESS: _____ **Phone#:** _____

_____

CERTIFICATION INFORMATION: (PLEASE CHECK THE APPROPRIATE BOX)

☐ **CERTIFIED NURSE MIDWIFE** ☐ **PSYCHIATRIC/MENTAL HEALTH SPECIALIST**

☐ **NURSE PRACTITIONER**

☐ **Procedures being performed by the APRN are within competency of their certification specialty.**

OR

☐ **Procedures being performed by the APRN that are not within competency of their certification specialty are listed below:**

(Please provide documentation of training and competency for each procedure- see instructions)

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

If the authority to prescribe controlled substances has been delegated to the NP under this agreement, we acknowledge that by law the APRN is not authorized to prescribe Schedule I controlled substances as defined in O.C.G.A. § 16-13-25 or Schedule II controlled substances as defined in O.C.G.A. §16-13-26.

_____ _____

APRN SIGNATURE **DATE**

_____ _____

PHYSICIAN SIGNATURE **DATE**

FORM C – INSTRUCTIONS FOR COMPLETION

(must include the **Delegating Physician and APRN signatures and dates**)

ILLEGIBLE FORMS ARE NOT ACCEPTED

***FOR ANY MEDICAL PROCEDURES PERFORMED BY THE APRN WHICH ARE NOT WITHIN COMPETENCY OF THEIR CERTIFICATION SPECIALTY, documentation of competency is required**. Some of these procedures may include chest tubes, central lines, arterial lines, intubations, joint aspirations and injections (specify joint/s,) trigger point injections, stress test, implanted birth control, colposcopy, thoracentesis, bronchoscopy, lumbar puncture, bone marrow biopsy, etc. The additional documentation should include the following for EACH MEDICAL PROCEDURE:

- Documentation of training the APRN has received for this procedure (such as school curriculum or at a previous medical practice)
- Number of times the delegating physician has supervised this procedure being performed by the APRN (minimum of 10)
- Number of times this procedure has been performed by the APRN without supervision (minimum of 10)
- Patient outcomes, including any complications
- Time frame in which the on-the-job training occurred
- Signature and date of the delegating physician

IF ON-THE-JOB TRAINING HAS NOT BEEN COMPLETED, PER THE GUIDELINES GIVEN, PLEASE REMOVE THE PROCEDURE(S) FROM FORM C AND RESUBMIT. A NEW FORM C AND TRAINING DOCUMENTATION MAY BE SUBMITTED ONCE THE ON-THE-JOB TRAINING IS COMPLETE.

Please note: This form can be completed using the GCMB website. Type the appropriate information on Form C on-line, print the form, and obtain signatures. Electronic signatures are NOT accepted.

Revised: 10/2015