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."

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	**E-MAIL ADDRESS (REQUIRED)**	DATE
______	______	______
APRN SIGNATURE	**E-MAIL ADDRESS (REQUIRED)**	DATE

NURSE PROTOCOL AGREEMENT

(*Changes may only be made by authorized Georgia Composite Medical Board staff.)

Please carefully review the terms of this agreement, pursuant to O.C.G.A 43-34-25, and input all information that applies to the APRN and Delegating Physician, where indicated.*

THIS NURSE PROTOCOL AGREEMENT ("Agreement") is entered into on

________________________________(mm/dd/yyyy).

Pursuant to O.C.G.A. Section 43-34-25(g.1), a physician at a location that maintains evidence-based clinical practice guidelines and is accredited by an accrediting body approved by the Board such as Joint Commission may enter into a nurse protocol agreement with not more than eight advanced registered nurses at any one time and supervise not more than four advanced registered nurses.

PLEASE PRINT LEGIBLE:

***Information regarding APRN:**

The name of the APRN under this Agreement is____________________________. The APRN is a registered professional nurse licensed by the Georgia Board of Nursing and recognized by said Board as a nurse practitioner.

APRN's Address:	
Telephone #:	
License #:	
DEA #:	
Email Address:	

(DEA# must be provided to the Georgia Composite Medical Board within 30 days of being issued)

***Information regarding DELEGATING PHYSICIAN**:

The name of the Physician under this Agreement is Dr.____________________________________, a________(MD or DO) licensed by the Georgia Composite Medical Board.

Delegating Physician's Practice Address:	
Telephone #:	
License #:	
DEA #:	
Email Address:	

THE COMPARABLE SPECIALTY AND FIELD OF PRACTICE OF THE APRN AND DELEGATING PHYSICIAN IS_____________________________________.

***Description of Practice (Family Medicine, Urgent Care, etc).:**

***Practice Locations**:
Physician and APRN shall collaborate in the treatment and management of patients at the following medical practice(s) ("Practice"):

Primary Practice:	
Address:	

Additional Location:	
Address:	

Additional Location:	
Address:	

*Please attach an **addendum page** for any additional locations.*

***Patient Population treated by APRN** (based on NP's national certification)**:**

RECITALS:

APRN and Physician desire to enter into this Agreement in order to establish between them a nurse protocol agreement as that term is contemplated in O.C.G.A. § 43-34-25; and

This Agreement is made by APRN and Physician for the purpose of defining the scope of prescriptive authority and other medical acts to be exercised by APRN in compliance with the applicable sections of O.C.G.A. § 43-34-1 *et seq.* (the "Georgia Medical Practice Act") and O.C.G.A. § 43-26-1 *et seq.* (the "Georgia Registered Professional Nurse Practice Act") and the administrative rules and regulations promulgated by their respective licensing boards; and

This Agreement shall not be construed as limiting, in any way or to any extent, the scope of practice authority provided to APRN pursuant to the Georgia Registered Professional Nurse Practice Act and the administrative rules and regulations promulgated pursuant thereto; and

This Agreement applies only with respect to APRN's professional activities in the practice conducted by Physician at the address listed for Physician above.

NOW, THEREFORE, for mutual promises and adequate consideration, APRN and Physician agree as follows:

1 **Incorporation of Recitals**. The recitals contained above are incorporated into and made a part of this Agreement.

2 ***APRN's Authority and Parameters.** Subject to the limitations set forth herein below, the APRN may order the following when necessary in the management and treatment of such acute illnesses or stable chronic illnesses. In rendering these services, APRN shall exercise the requisite standard of care, defined as the exercise of at least that degree of skill, care and diligence as would ordinarily be rendered by advanced practice registered nurses generally under like and similar circumstances.

☐ Appropriate drugs (as set forth in the protocol agreement)

☐ Diagnostic studies -lab work

☐ Diagnostic studies -x-rays

☐ Medical devices

☐ Medical treatments

*APRN may refer to and use the following guidelines (in their latest, current edition) and reference sources when treating and managing patients pursuant to this Agreement:

i.
ii.
iii.
iv.
v.
vi.
vii.

*Please attach an **addendum page** for any additional guidelines/sources.*

☐ *3. APRN will not be providing telemedicine services.*

☐ *3a. APRN will be providing telemedicine services and assert that this is within the scope of practice in accordance with* **Rule 360-3-.07.**

Form C

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

☐ *4a. Procedures being performed by APRN which are not within competency of their certification specialty requires completion of Form C. Please submit a separate Form C for each procedure.*

5. Medical Imaging Tests (Please choose applicable statement):

☐ **Medical Imaging tests may be ordered by APRN. As used herein, the phrase "medical imaging tests" means CT scans, MRI scans, PET scans or nuclear medicine scans. Orders should include the indication for the test as well as the name, address, and phone number of the delegating physician.**

OR

☐ **APRN is NOT authorized to order any "medical imaging tests" as defined above.**

6. Documentation. APRN shall document in writing in each patient's medical record, electronically or otherwise, those acts performed by APRN which comprise medical acts delegated by Physician to APRN under this Agreement.

7. *Physician Availability; Other Designated Physicians (Please choose applicable statement):

☐ At all times when APRN is acting under this Agreement, either Physician or an "Other Designated Physician" shall be readily available to APRN for immediate consultation by direct communication or by telephone or other mode of telecommunication. In the event Physician is not readily available for such consultation, the Other Designated Physician(s) listed at the end of this Agreement in the section entitled "Concurrence of Other Designated Physicians" or Form

A(s) (filed with the GA Medical Board with original signature(s)) shall be available for such consultation in accordance with the Georgia Composite Medical Board Rule 360-32-.01.

OR

☐ The APRN is only acting under this agreement with the Delegating Physician; therefore, when the delegating physician is unavailable, by direct communication or by telephone or other mode of telecommunication, the APRN will not see patients.

8. **Physician Evaluation and Follow-Up**. Patients treated by APRN shall be evaluated and followed-up by Physician (or, in the event Physician is not available, then an Other Designated Physician) on a time interval determined by Physician in accordance with the parameters of the acts delegated to APRN and pursuant to such standards as may be from time to time determined by the Georgia Composite Medical Board.

9. ***Controlled Substances** (Please choose applicable statement):

☐ A patient who receives a prescription drug order for any controlled substance pursuant to this Agreement shall be evaluated or examined by Physician (or Other Designated Physician) on at least a quarterly basis or at a more frequent interval as from time to time determined by the Georgia Composite Medical Board. APRN shall not have the authority to order or prescribe Schedule I controlled substances as defined in O.C.G.A. § 16-13-25 or to prescribe Schedule II controlled substances as defined in O.C.G.A. §16-13-26.

OR

☐ APRN shall not have the authority to order or prescribe **Schedule I-V controlled substances**.

10. **Consultation with Physician Required in Certain Situations.** On-site evaluation or telephone consultation by Physician (or Other Designated Physician) is required in the following situations: a. situations that pose an immediate threat to the patient's life or bodily function, 2) conditions that fail to respond to the management plan within an appropriate time frame, 3) findings that are unusual or unexplained, 4) whenever a patient requests physician consultation, 5) whenever there is a material adverse outcome, and 6) in circumstances requiring medical management that is beyond APRN's scope of practice, 7) Other (specify)______________________________
____.

11. **Physician Must Interpret Imaging Studies.** With respect to x-rays, ultrasounds or advanced radiographic imaging tests ordered by APRN, all such tests shall be read and interpreted by a physician who is trained in the reading and interpretation of such tests. Further, a report of such x-ray, ultrasound or radiographic imaging test may be reviewed by APRN with a copy of such report forwarded to Physician.

12. ***Prescription Drug Refills**. APRN may order appropriate refills provided that APRN shall not have the authority to order refills of any drug for more than_______months (< or =12 months) from the date of the original order except I the case of oral contraceptives, hormone replacement therapy, or prenatal vitamins which may be refilled for a period of 24 months as provided in O.C.G.A. § 43-34-25.

13. **Abortion Drugs Prohibited.** APRN shall not have the authority to prescribe/order drugs intended to cause abortion to occur pharmacologically or to perform an abortion.

14. **Documentation of Drug Orders**. APRN shall document prescription orders in the patient's medical record. In addition a duplicate prescription or a photocopy or electronic equivalent copy of the prescription drug or device order that is given to the patient must be maintained in the patient's medical record.

15. **Prescription Forms**. APRN shall sign and shall issue prescriptions/orders on a form which contains the following:

a. The name, address, and telephone number of the delegating physician
b. The name of the APRN and the <u>APRN's DEA number</u> (if applicable)
c. The name and address of the patient
d. The drug prescribed and the number of refills
e. Directions to the patient with regard to taking and dosage of the drug

16. ***Professional Drug Samples (**(<u>Please choose applicable statement</u>):

☐ APRN <u>**is**</u> authorized by Physician to request, receive and sign for professional samples and may distribute professional samples to patients.

OR

☐ APRN <u>**is not**</u> authorized by Physician to request, receive or sign for professional samples and may distribute professional samples to patients.

17. ***Physician Review and Signing of Records.** Physician shall review and sign patient records generated by APRN periodically based on the following minimum accepted standard of medical practice:

a. 100% of patient records for such patients receiving prescriptions for controlled substances. Such review shall occur <u>at least quarterly</u> after issuance of the controlled substance prescription.

b. 100% of patients' records in which an adverse outcome has occurred. Such review shall <u>occur no more than 30 days after</u> the discovery of an adverse outcome.

c. _____% (> or = 10%) of all other patient records. Such review shall occur <u>at least annually</u>.

18. **Emergency Situations**. If an emergency situation should occur respecting any patient being treated by APRN, the APRN shall respond by summoning trained emergency responders (911), begin initial stabilizing care and seek immediate consultation with the Physician or Other Designated Physician.

19. **Pharmacology Training**. Delegating Physician shall ensure that APRN receives pharmacology training appropriate to Physician's scope of practice at least annually. Documentation of such training shall be maintained by Physician and provided to the Georgia Composite Medical Board upon request.

20. **Documentation Available for Composite Board**. Copies of this Agreement and supporting documentation shall be available at the Practice site and open to review by the Georgia Composite Medical Board at any time, including documentation of Physician's quarterly onsite observation (review of the medical acts performed by APRN) and documentation of the pharmacology training received by APRN each year.

Miscellaneous Matters

1. **Annual Review; Board Approval**. This Agreement shall be reviewed, revised and updated (as necessary) annually by APRN and Physician. Further, this Agreement shall be made available for review to the Georgia Board of Nursing by APRN if requested by said Board and shall be submitted for review to the Georgia Composite Medical Board by Physician within thirty (30) days following execution. In the event the Georgia Composite Medical Board determines that this Agreement needs to be modified to comply with the Georgia Composite Medical Board standards or requirements, the parties agree to make such changes promptly following receipt of notice from the Georgia Composite Medical Board.

2. **Termination with Cause**. Either party may terminate this Agreement for cause, effective immediately, upon delivery of written notice to the other party, in the event of either of the following: (i) either Physician's or APRN's employment is terminated, or (ii) either Physician's or APRN's license to practice medicine or nursing, as the case may be, is revoked or suspended.

3. **Termination without Cause**. Either party may terminate this Agreement without cause by giving the other party at least thirty (30) days advance written notice.

4. **Notification to the Board of Termination**. Physician shall notify the Georgia Composite Medical Board of the termination of this Agreement within ten (10) days of the date of termination.

5. **Governing Law**. This Agreement shall be governed by and construed in accordance with the laws of the State of Georgia.

6. **Entire Agreement**. This Agreement represents the entire understanding of the parties and supersedes any prior written or oral agreement between the parties. There are no agreements, understandings or representations, either oral or written, relating to the subject matter of this Agreement which are not fully expressed herein.

7. **Amendments must be in Writing**. This Agreement may only be amended by way of a written instrument signed by both parties.

STATEMENT OF APPROVAL

We, the undersigned, agree to the terms of this agreement as set forth in this document.
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.

APRN Printed Name:	
APRN's Signature:	
Date:	

Delegating PHY Printed Name:	
Delegating PHY Signature:	
Date:	