FORM A
DESIGNATED PHYSICIAN INFORMATION
For the Protocol Agreement between

DELEGATING PHYSICIAN _____ LICENSE #_____

APRN _____ LICENSE #_____

The DESIGNATED Physician CANNOT be the DELEGATING PHYSICIAN!

The designated physician is available for consulting purposes in the ABSENCE of the delegating physician for the protocol agreement indicated above.

DESIGNATED PHYSICIAN INFORMATION			
LAST NAME	**FIRST NAME**	**MIDDLE NAME**	DEGREE: (MD OR DO)

GEORGIA LICENSE NUMBER	DEA REGISTRATION NUMBER	**SPECIALTY AREA (must be the SAME as the specialty area of the DELEGATING Physician**:

DESIGNATED PHYSICIAN PRACTICE ADDRESS:			
STREET NUMBER	STREET NAME		SUITE #
CITY	STATE	ZIP CODE	COUNTY
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		

LICENSE HISTORY	
CURRENT LICENSE EXPIRATION DATE:	
CURRENT STATUS OF LICENSE:	
ANY RESTRICTIONS ON CURRENT LICENSE:	

360-32-.02(3) (c) Such designation must include the printed name, license number, and signature of the designated physician with an affirmation from the designated physician that he or she has agreed to serve as a designated physician and has reviewed the nurse protocol agreement and concurs with the terms of the agreement.

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.

_____ _____

DESIGNATED PHYSICIAN SIGNATURE DATE