APRN APPLICATION CHECKLIST

HOW TO GET YOUR FILE REVIEWED THE FIRST TIME!!

IF APPLICATION IS INCOMPLETE, YOU WILL BE NOTIFIED BY EMAIL. IF REQUESTED INFORMATION IS NOT SUBMITTED WITHIN 30 DAYS OF NOTIFICATION, YOUR APPLICATION WILL BE CLOSED!!

Please send application to:
GCMB, APRN Department, 2 Peachtree Street, N.W., 6th Floor, Atlanta, GA 30303

Your approval letter will be mailed to your delegating physician's practice.

___ Registration Form (ORIGINAL – must be complete and SIGN + include SPECIALTY of Physician and APRN)

___ $150 Fee (check or money order made payable to: GCMB)

___ License Verification
  o submit copy of current APRN license
  o submit copy of national certification (wallet card, letter, or certification should include expiration date)
  o submit copy of specialty training (if applicable)

___ Protocol Agreement (we prefer the board template). Original signatures required
  o page 1 – DATE and physician SPECIALTY
  o page 2 –
    ▪ DESCRIPTION OF PRACTICE
    ▪ PRACTICE LOCATION
    ▪ PATIENT POPULATION (specify age group)
  o page 3 – #2 (select appropriate options)
  o page 4 –
    ▪ LIST appropriate references for CLINICAL GUIDELINES (text +/- online resources)
    ▪ #3 (select option for Radiographic Imaging Test)
    ▪ #5 (select option for Physician Availability)
  o page 5 –
    ▪ #7 (select option for controlled substances)
    ▪ #10 (fill in __##_ months)
    ▪ #11 (select option for Abortion Drugs)
  o page 6 –
    ▪ #14 (select option for Professional Drug Samples)
    ▪ #15 (fill in - select option for Physician Review and Signing of Records)
  o page 8 (include signatures and dates)
  o page 9 (information about designated physician)

___ Form A (must complete ONE for EACH designated physician)

___ Form B (complete if you are terminating previous delegating physician)

___ Form C (use revision 10/2015)
  o select certification
  o select a procedure request category (copies of 10 un-supervised/10 supervised cases)