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).

***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:**

***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 ***Radiographic Imaging Tests** (Please choose applicable statement):

☐ Radiographic imaging tests may be ordered only by APRN in the case of a life-threatening situation as defined below. As used herein, the phrase "radiographic imaging tests" means CT scans, MRI scans, PET scans or nuclear medicine scans, and the phrase "life-threatening situation" means an emergency situation in which a patient's life or physical well-being will be placed in significant, material jeopardy if such testing is not performed immediately.

OR

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

4 **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.

5 ***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.

6 **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.

7 ***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**.

8 **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: 1) 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)_____ _____.

9 **Physician Must Interpret Imaging Studies**. With respect to x-rays, ultrasounds or 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.

10 ***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.

11 **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.

12 **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.

13 **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 APRN's DEA number (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

14 ***Professional Drug Samples ((**Please choose applicable statement):

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

OR

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

15 ***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 at least quarterly after issuance of the controlled substance prescription.

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

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

16 **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.

17 **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.

18 **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.

APRN Printed Name:	
APRN's Signature:	
Date:	

Delegating PHY Printed Name:	
Delegating PHY Signature:	
Date:	

CONCURRENCE OF OTHER DESIGNATED PHYSICIAN(S)

By signing below, I acknowledge that I have been designated as an Other Designated Physician respecting the above and foregoing Nurse Protocol Agreement. I certify that my field and scope of medical practice is _____**,** which is comparable to that of the APRN and the same as that of the Delegating Physician. I concur with and agree to the terms of the above and foregoing Nurse Protocol Agreement.

Designated PHY Printed Name:	
Designated PHY Signature:	
Date:	
GA License#:	
DEA#:	
Practice Location:	

CONCURRENCE OF OTHER DESIGNATED PHYSICIAN(S)

By signing below, I acknowledge that I have been designated as an Other Designated Physician respecting the above and foregoing Nurse Protocol Agreement. I certify that my field and scope of medical practice, namely _____ is comparable to that of the APRN and the same as that of the Delegating Physician. I concur with and agree to the terms of the above and foregoing Nurse Protocol Agreement.

Designated PHY Printed Name:	
Designated PHY Signature:	
Date:	
GA License#:	
DEA#:	
Practice Location:	