

APRN APPLICATION CHECKLIST

HOW TO GET YOUR FILE REVIEWED THE FIRST TIME!!

___ **Registration Form** (complete and **SIGN** + include **SPECIALTY** of Physician and APRN)

___ **\$150 Fee**

___ **Protocol Agreement** (we prefer the board template)

- **page 1** – DATE and physician **SPECIALTY**
- **page 2** –
 - **DESCRIPTION OF PRACTICE**
 - **PRACTICE LOCATION**
 - **PATIENT POPULATION** (specify age group/correspond to certification specifics)
- **page 3** – #2 (select appropriate options)
- **page 4** –
 - **LIST** appropriate references for **CLINICAL GUIDELINES** (text +/- online resources)
 - #3 (select option for Radiographic Imaging Test)
 - #5 (select option for Physician Availability)
- **page 5** –
 - #7 (select option for controlled substances)
 - #10 (fill in _##_ months)
 - #11 (select option for Abortion Drugs)
- **page 6** –
 - #14 (select option for Professional Drug Samples)
 - #15 (select option for Physician Review and Signing of Records)
- **page 8** (include signatures and dates)
- **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 11/2015)

- select certification
- select a procedure request category (copies of 10 un-supervised/10 supervised cases)

___ **Form D** (complete if APRN DEA is available)

___ **License Verification**

- submit copy of current APRN license
- submit copy of national certification
- submit copy of specialty training (if applicable)

THANK YOU FOR YOUR COOPERATION!

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!!