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!!

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

_____ $150 Fee

___ License Verification

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

_____ 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)
- **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 10/2015)

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

___ Form D (complete if APRN DEA is available)

THANK YOU FOR YOUR COOPERATION!
Your approval letter will be mailed to your delegating physician's practice.

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