FORM B
ADVANCED PRACTICE REGISTERED NURSE (APRN)
NURSE PROTOCOL AGREEMENT
TERMINATION NOTIFICATION FORM

ONLY COMPLETE this form if you are TERMINATING from an APRN you are currently supervising.

360-32-.05 (5) A delegating physician shall notify the Georgia Composite Medical Board within ten (10) working days of the date of termination of a nurse protocol agreement with the delegating physician and APRN.

Delegating Physician Statement:

I hereby serve notice to the Georgia Composite Medical Board that I have submitted my

termination with APRN _____
(APRN Full Name) – please print legibly

_____effective:_____/_____/_____.
(license number) (Month) (Day) (Year)

_____ _____
Delegating Physician Name – (please print legibly) License Number

_____ _____
Delegating Physician Signature Date Signed

This termination includes all, if any, other designated physicians approved for this APRN under my request.

APRN Statement:

I hereby serve notice to the Georgia Composite Medical Board, that I have accepted the

termination of _____
(Delegating Physician Full Name)– please print legibly

effective:_____/_____/_____
(Month) (Day) (Year)

_____ _____
APRN Signature Date Signed

THIS FORM MAY BE SUBMITTED BY FAX: 770-408-5879