ATTACH CHECK HERE

GEORGIA COMPOSITE MEDICAL BOARD (GCMB) USE ONLY

DATE RECEIVED _____ **DATE COMPLETED** _____

ALL FEES ARE NONREFUNDABLE*

FEES ARE SUBJECT TO CHANGE

DELEGATING PHYSICIAN INFORMATION

LAST NAME	**FIRST NAME**	**MIDDLE NAME**	**DEGREE: (MD OR DO)**

GEORGIA LICENSE NUMBER DEA REGISTRATION NUMBER	**Please check, if the delegating physician is a:** ☐ **Georgia state employee** ☐ **Georgia county employee** ☐ **Georgia city employee** **If you checked any of the boxes above, please submit proof of employment.**	PRACTICE DESCRIPTION AND SPECIALTY AREA: # OF LOCATIONS- TO INCLUDE SATELLITE SITE(S):

PRACTICE ADDRESS WHERE APRN IS PRACTICING UNDER THIS PROTOCOL AGREEMENT:
(If more than one location, list the primary practice location for the APRN)

STREET NUMBER	STREET NAME		SUITE #
CITY	STATE	ZIP CODE	COUNTY
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		

ADVANCED PRACTICE REGISTERED NURSE (APRN) INFORMATION

RN#:_____

☐ **Nurse Practitioner - specify TYPE - Family, Adult, Pediatric, etc.**_____

☐ **Certified Nurse Midwife**

☐ **Clinical Nurse Specialist - Psychiatric/Mental Health**

☐ **Clinical Nurse Specialist - OTHER than Psychiatric/Mental Health**

DEA REGISTRATION

#:_____
(IF ALREADY ISSUED)

☐ CHECK HERE IF PENDING OR WILL APPLY LATER

LAST NAME	**FIRST NAME**	**MIDDLE**

LICENSE HISTORY

Delegating Physician	**Advanced Practice Registered Nurse (APRN)**
CURRENT LICENSE EXPIRATION DATE: (MM/DD/YY)	CURRENT LICENSE EXPIRATION DATE: (MM/DD/YY)
ANY RESTRICTIONS ON CURRENT GA LICENSE:	ANY RESTRICTIONS ON CURRENT APRN LICENSE:
CURRENT STATUS OF LICENSE:	CURRENT STATUS OF LICENSE:

The undersigned acknowledges having read and understood Rule 360-32 "Nurse Protocol Agreements Pursuant to OCGA 43-34-25."

_____ _____ _____
DELEGATING PHYSICIAN SIGNATURE **E-MAIL ADDRESS (REQUIRED)** DATE

_____ _____ _____
APRN SIGNATURE **E-MAIL ADDRESS (REQUIRED)** DATE