Georgia Board of Nursing – Information for APRNs Seeking Prescriptive Authority

If you plan to seek prescriptive authority in Georgia under O.C.G.A. § 43-34-25 you must first have a nurse protocol agreement approved by the Georgia Composite Medical Board. Please use the following guide to complete the process:

1. Submit your application for authorization as an APRN to the Georgia Board of Nursing.

2. After you have been authorized as an APRN by the Georgia Board of Nursing please visit the Georgia Composite Medical Board's website at www.medicalboard.ga.gov, click on "Professional Resources," select "Applications Center" and select the link for "Nurse Protocol (APRN) Agreement." Follow the online instructions to submit your application for approval.

3. After your nurse protocol agreement has been approved by the Georgia Composite Medical Board please contact the Drug Enforcement Agency (DEA) at www.deadiversion.usdoj.gov/drugreg for information on submitting your application for a DEA number. Please note, you must be authorized as an APRN by the Georgia Board of Nursing and have a nurse protocol agreement approved by the Georgia Composite Medical Board prior to seeking a DEA number.

4. Georgia law requires all prescribers to register with the Georgia Prescription Drug Monitoring Program. Please visit https://dph.georgia.gov/pdmp for information regarding the registration process.

Georgia Board of Nursing

237 Coliseum Drive
Macon, Georgia 31217
(404) 424-9966
www.sos.ga.gov/georgia-board-nursing

Application for Licensure By Reinstatement as an Advanced Practice Registered Nurse
Application Fee: $90.00 + 10.00 Processing Fee
Fees Are Non-refundable

Date Entered _____
Receipt # _____
Submitted $ _____
Certificate # _____
Date Issued _____

❒ Please check this box if you are a military spouse or a transitioning service member of the United States armed forces (including the National Guard).

Demographic Information
Please Print Legibly or Type all Information

Last Name:	First Name:	
Middle Name:	Previous Name(s):	
Social Security Number:	Date of Birth:	
Gender: ❒ Male ❒ Female	Email:	

Physical Address Information – Applicants must provide a physical address of record.
A post office box is not acceptable for this field.

Physical Address:		
City:	State:	Zip:

Mailing Address Information - Pursuant to O.C.G.A. §43-1-2(k), if issued a license, your mailing address and license number are public information and will appear on the Board's. A post office box may be used for this field.

Mailing Address:		
City:	State:	Zip
Phone:	Alternate Phone:	

Georgia Licensure and Authorization Information
Applicants must provide information regarding their original license and authorization issued by the Georgia Board of Nursing

Georgia RN License Number:

Please select the APRN role for which you are seeking reinstatement of authorization.
You must submit a separate application for each authorization.

❒ Certified Nurse Midwife ❒ Certified Nurse Practitioner ❒ Certified Registered Nurse Anesthetist
❒ Clinical Nurse Specialist-Psychiatric/Mental Health ❒ Clinical Nurse Specialist

APRN Certification Information
Applicants must provide verification of national certification from one of the certifying bodies listed in Board Rule 410-11-.12.

Name of National Certifying Body:	
National Certification Number:	Date of Certification:

APRN Nursing Education Information

To ensure that our licensure records contain all information regarding your APRN education please complete the section below.

APRN School Name:			
Location of APRN Education Program:	City:	State:	Zip:
Date of Graduation:	Degree Awarded: ❒ Associate Degree ❒ Baccalaureate Degree ❒ Master's Degree ❒ Doctorate ❒ Other		

Active Practice Information

Board Rules Chapter 410-11 require that applicants document one of the following:

I have graduated from an advanced practice nursing education program within the four (4) years preceding the date of this application:

❒ No ❒ Yes

I have practiced as an advanced practice registered nurse (based on the definition of "Advanced Practice Nursing" found in O.C.G.A. §43-26-3) at least five hundred (500) hours within the four (4) years preceding the date of this application and have provided the employment information on the grid below:

❒ No ❒ Yes

Employer Name and Address	Location (City/State)	Position/Title	Dates of Employment (Month/Year to Month/Year)	APRN Licensure Required	Number of Hours Worked

A completed verification of employment form must be submitted for each employer listed on this grid.
If your employer uses a third party to verify employment it is the applicant's responsibility to obtain the employment documentation and submit it with the application packet.

Any applicant practicing as a registered nurse without licensure will be subject to Board review. The Board requires a personal, detailed, letter of explanation and detailed employment information from the employer's human resources department for any advanced nursing practice in Georgia without a valid authorization.

Applicants that have not met the active practice requirement with the previous four years by graduating from an advanced practice nursing education program or practicing at least five hundred hours must complete a Board approved reentry program as defined in Board Rule 410-4-.04.

Criminal and Disciplinary Information

Failure to reveal an offense, arrest, ticket, or citation may subject your license to a disciplinary order and fine.

Have you ever been arrested? ❒ No ❒ Yes

If yes, please submit, with your application, a certified copy of the court records showing the final disposition of all charges and letter of explanation which addresses each charge.

Note: The answer to this question is "Yes" if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled and completed probation under First Offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.

Has any licensing authority in Georgia or any other jurisdiction ever refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license, certificate or multi-state privilege held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you? ❒ No ❒ Yes

Within the past five (5) years have you been addicted to and/or treated for the use of alcohol or any other drug? ❒ No ❒ Yes

Are you currently under investigation or is a disciplinary action pending against your nursing license or any other license or certification you hold in any state or territory of the United States? ❒ No ❒ Yes

Are you currently a participant in a state board/designee monitoring program including alternative to discipline, diversion or a peer assistance program? ❒ No ❒ Yes

Have you ever been terminated from an alternative to discipline, diversion, or a peer assistance program due to unsuccessful completion? ❒ No ❒ Yes

Do you currently possess any condition which may in any way impair your ability to practice or otherwise alter your behavior as it relates to the practice of nursing? ❒ No ❒ Yes

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Citizenship and Immigration Information

Georgia law requires applicants to submit a copy of your Secure and Verifiable Document. This includes a copy of your driver's license, United States Passport or a copy of your current immigration document(s) which includes your alien identification number, I-94 number and SEVIS ID if required.

A complete list of secure and verifiable documents published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status. This list may be found on the Board's website at this address: www.sos.ga.gov/georgia-board-nursing

Applicant Affidavit

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia Board of Nursing and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _____ I am a United States citizen 18 years of age or older. Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated on page 9 of the application packet.

2) _____ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. Please

submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.

Under penalties of perjury, I understand that any false or misleading information in, or in connection with my application, may be cause for denial or revocation of licensure. In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia Board of Nursing and/or criminal prosecution.

_____ _____

Printed Name of Applicant Applicant Signature

Sworn to and subscribed before me this _____ day of _____, 20_____.

_____ _____

Signature of Notary Public Commission Expiration Date

- THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY -

Application Checklist

To ensure that your application is complete, please use the following checklist:

Enclose a check or money order payable to the Georgia Board of Nursing in the amount of $90.00 +$10.00 processing fee. Remember—application fees are nonrefundable.

Enclose a completed verification of employment or nursing education transcripts (if required).

Enclose secure and verifiable documentation of United States citizenship or legal immigration status.

Request your national certifying body to provide verification of national certification as an advanced practice registered nurse to the Board for review. Verification of certification should be submitted electronically from the certifying body to nursing@sos.ga.gov.

Mail your completed application to:

Georgia Board of Nursing
237 Coliseum Drive Macon,
Georgia 31217
(404) 424-9966
www.sos.ga.gov/georgia-board-nursing

You may check your application status by visiting the Board's website at www.sos.ga.gov/georgia-board-nursing and click on "Licesing Services" and "Application Status."

GEORGIA BOARD OF NURSING
237 Coliseum Drive
Macon, Georgia 31217

VERIFICATION OF EMPLOYMENT FOR APPLICANTS FOR LICENSURE BY REINSTATEMENT

Section I (To be completed by applicant)

Submit this form to your employer to verify your employment and the numbers of hours worked. The name and address of your employer on this form must match the name and address you listed under "Employment History" on your application. Ask the employer to complete this form and place it in a sealed envelope for you to submit with your application or submit it by email to nursing@sos.ga.gov or by fax to 877-371-5712.

Applicant Last Name:	Applicant First Name:	
Physical Address:		
City:	State:	Zip:
Phone:	Email:	

I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia Board of Nursing. I understand this information is required as part of the application for licensure process.

_____ _____

Applicant Signature Date

Section II (To be completed by employer)

Please complete the form in its entirety. Be sure to accurately document the employee's position/title and whether or not licensure as a registered nurse was required. The completed and notarized form may be provided to the applicant or submitted directly to the Georgia Board of Nursing by email to nursing@sos.ga.gov or by fax to 877-371-5712.

Facility/Business/Employer Name:		
Physical Address:		
City:	State:	Zip:
Phone:	Email:	

Employer Information – Please Answer Each Question:

Is this a federal agency of the United States Government? ❒ No Yes ❒

Is this an acute care inpatient hospital? ❒ No Yes ❒

Is this a long term acute care facility (LTAC)? ❒ No Yes ❒

Is this an ambulatory surgical center or obstetrical facility as defined in O.C.G.A. §31-6-2? ❒ No Yes ❒

Is this a skilled nursing facility which has at least one hundred (100) beds and provides health care to patients with similar health care needs as those patients in a long term acute care facility? ❒ No Yes ❒

Applicant's Position/Title:

Is an APRN license a qualification/requirement for employment in this position? ❒ No Yes ❒

If different location than the employer listed on the first page, please identify the physical location where the employee practiced

Facility/Business/Employer Name:		
Physical Address:		
City:	State:	Zip:
Phone:	Email:	

Dates of Employment:

Employed From_____(Month/Year) to _____(Month/Year)

Were there any periods of extended absence during employment? ❒ No Yes ❒

If yes, please provide dates"_____(Month/Year) to _____(Month/Year)

Please complete the grid below:

Year	Hours Worked	Job Title/Description

I hereby certify that I am the custodian of records at the facility listed on this form and the information submitted on this form are true and correct statements of this applicant's employment with our facility.

_____ _____

Employer Representative Printed Name Employer Representative Title

_____

Employer Representative Signature

Sworn to and subscribed before me this _____ day of _____, 20_____.

_____ _____

Signature of Notary Public Commission Expiration Date

- THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY -

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Criminal Background Consent Form		
Last Name:	First Name:	
Middle Name:	Previous Name(s):	
Social Security Number:	Date of Birth:	
Gender: ❒ Male ❒ Female	Race:	
Physical Address:		
City:	State:	Zip:

I hereby authorize the Georgia Board of Nursing ("Board") to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia. I give consent to the Board to perform periodic criminal history background checks for the duration of my licensure with this state.

_____ _____

Applicant Signature Date

- THIS FORM MUST NOT BE SIGNED ELECTRONICALLY -