FORM C
ADVANCED PRACTICE REGISTERED NURSE (APRN)
PROTOCOL WORKSHEET

PLEASE PRINT LEGIBLY:

APRN NAME:____ **DATE OF BIRTH:**_______________

RN#:____ **DEA #:** _____________________

ADDRESS: ____
Street Address

____
City State Zip Code

CERTIFICATION INFORMATION: (PLEASE CHECK THE APPROPRIATE BOX)

____ **CERTIFIED NURSE MIDWIFE** ____ **PSYCHIATRIC/MENTAL HEALTH SPECIALIST**

____**NURSE PRACTITIONER**

PLEASE LIST COMMONLY USED MEDICATIONS (SPECIFIC DRUGS NOT DRUG CATEGORIES)

1.	________	**6.**	________	**11.**	________	**16.**	________
2.	________	**7.**	________	**12.**	________	**17.**	________
3.	________	**8.**	________	**13.**	________	**18.**	________
4.	________	**9.**	________	**14.**	________	**19.**	________
5.	________	**10.**	________	**15.**	________	**20.**	________

ROUTINELY PERFORMED PROCEDURES (PLEASE LIST)

1.	________	**6.**	________	**11.**	________	**16.**	________
2.	________	**7.**	________	**12.**	________	**17.**	________
3.	________	**8.**	________	**13.**	________	**18.**	________
4.	________	**9.**	________	**14.**	________	**19.**	________
5.	________	**10.**	________	**15.**	________	**20.**	________

PROTOCOL REFERENCE SOURCES (NOTE: REFERENCE TEXTBOOKS <u>ARE NOT</u> APPLICABLE)

1. ____
2. ____
3. ____
4. ____
5. ____

<u>The APRN is not authorized to dispense medicines with the intent to cause an abortion.</u>

____ _________________________
APRN SIGNATURE **DATE**

____ _________________________
PHYSICIAN SIGNATURE **DATE**