FORM D
ADVANCED PRACTICE REGISTERED NURSE (APRN)
DEA INFORMATION

INSTRUCTIONS:

Type or print clearly. Complete all information requested.

DELEGATING PHYSICIAN INFORMATION

PHYSICIAN NAME: **(PLEASE PRINT LEGIBLY)**

_____

GEORGIA LICENSE NUMBER:

_____

DEA REGISTRATION NUMBER:

_____

APRN DEA INFORMATION

APRN NAME: **(PLEASE PRINT LEGIBLY)**

_____

APRN LICENSE NUMBER:

_____

DEA REGISTRATION NUMBER:

_____

DATE ISSUED:

_____

Please return the completed form to:
Georgia Composite Medical Board
Attn: APRN Department
2 Peachtree Street, N.W., - 36th Floor
Atlanta, GA 30303
Or by fax: 770-408-5879

_____ _____

Delegating Physician Telephone Number **e-mail address**

_____ _____

Delegating Physician Signature **Date**