



# Alabama Board of Nursing

## Critical Care Specialty or Advanced Protocol Application

Protocol Selected:

☐ Critical Care Specialty

☐ Critical Care Advanced

All information below must be completed in full and include detail. Simple, incomplete sentence answers are not appropriate and may cause a delay in approval. The ABN and ABME must approve the application. [Click here for the application instructions.](#)

| Contact Information  |  |
|--|--|
| CRNP Name  |  |
| License number   |  |
| Telephone Number (daytime)   |  |
| Email Address  |  |
| Collaborating Physician Name and Practice Specialty                          |  |
| License number   |  |
| Email Address  |  |
| Practice Site(s)   |  |
| Name of Practice Site(s)   |  |
| Facility Setting (office, hospital, etc.)                                    |  |
| Detailed Description of the Skill or Procedure                               |  |
| Procedure Name   |  |
| Purpose of the Procedure   |  |
| Description of the skill/procedure requested                                 |  |
| Medications to be injected if applicable                                     |  |
| Plan for Physician availability when CRNP performs this procedure            |  |
| List contraindications and limits to CRNP performing the procedure           |  |
| Plan for supervised practice and must follow specified protocol requirements |  |
| Quality Assurance Review/Adverse Outcome Plan if indicated per protocol      |  |



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CRNP Signature

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Date

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Physician Signature

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Date

**Note:** Submit or attach detailed information or supporting documents by e-mail in PDF or mail hardcopy to the address below **(DO NOT FAX)**. Print a copy for your records.

**Email (PDF):** [advancedpractice@abn.alabama.gov](mailto:advancedpractice@abn.alabama.gov)

**Mail:** Alabama Board of Nursing  
P.O. Box 303900  
Montgomery, AL 36130-3900