



# Alabama Board of Nursing

## Tunneled Central Venous Line Protocol Application

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 (A protocol is required for each requested procedure)                                                                                                                                                                                             |  |
| Description of the skill/procedure (Provide comprehensive details, including technique or energy device to be used, if applicable, as well as the name of the device, catheter, etc. Also, include how many times per month this procedure is performed in your practice). |  |
| 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                                                                                                                                                                                               |  |
| Does the CRNP's collaborating physician perform this procedure on a routine basis?                                                                                                                                                                                         |  |
| Quality Assurance Review/Adverse Outcome Plan if indicated per protocol                                                                                                                                                                                                    |  |



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CRNP/CNM 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