Orthopedic Specialty Protocol Request to Train

____ This CRNP/PA has been previously trained in the skills checked below and we wish to transfer the approval to perform these skills to our Collaborative Agreement/Registration Agreement. (Include copies of previously approved supervised practice)

_____This CRNP/PA wishes to transfer the approval to train to this Collaborative Agreement/Registration Agreement and will continue with supervised practice.

Before beginning the **initial training** for a CRNP/PA to perform Joint Injections the physician must request permission to do so from the Board of Medical Examiners. Complete this page to request approval to train the CRNP/PA to perform Joint Injections as part of the Orthopedic Specialty Protocol Request.

Request must include protocols as requested in Item 2 for:

CRNP/PA Name_____
Please Print

1. Check the procedures you wish to train the CRNP/PA to perform.

   Injections (According to the Orthopedic Approval Table) of:

   ___Acromioclavicular Joint ___Subacromial Bursa ___Olecranon Bursa

   ___Greater Trochanteric Bursa ___Knee joint ___Pes anserine bursa

2. **Include your protocol** for training as well as performance by the CRNP/PA (See the Orthopedic Specialty Protocol Table for Inclusions and Exclusions). (Template available upon request)

3. **Standard Approval Language**: "*Allowed to perform injections to sites named in the Orthopedic Approval Table with Board approved documentation of supervised practice completed under direct physician supervision. Total of ten (10) supervised injections for each site to be considered for approval and must be submitted within one year of approval to train. Five (5) injections for each site approved should be documented for annual maintenance of certification and this documentation may be kept at your practice location and available if asked to produce it. Mid-Levels may request approval to perform Orthopedic injections at remote site locations after documentation of supervised practice has been approved by the Board".*

Physician printed name: _____License # _____

Physician signature: _____ Date: _____

Training may not begin until you have been approved to train by both the Alabama Board of Medical Examiners and the Alabama Board of Nursing (CRNP). ***APPROVAL TO TRAIN WILL LAPSE IF DOCUMENTATION OF SUPERVISED PRACTICE IS NOT RECEIVED WITHIN ONE (1) YEAR!*