



**ALABAMA STATE BOARD OF MEDICAL EXAMINERS
SPECIALTY PROTOCOL TEMPLATE
(PLEASE TYPE THIS FORM)**

CRNP/CNM/PA NAME:
License Number:
Email Address:
Collaborating/Supervising Physician:
License Number:
Email Address:
Practice Specialty of Physician:
Practice Site(s) where you are requesting skill be performed:
Procedure Name:
Purpose of Procedure:
Description of Procedure (Give comprehensive details including technique used, energy device to be used if applicable):
What will be injected, if applicable:
Contraindications/Limits (for allowing Mid-Level practitioner to perform the procedure):
Plan for Supervised Practice:
Plan for Physician Availability:
Plan for Quality Assurance/Adverse Outcome review:

As collaborating/supervising physician, do you perform this procedure on a routine basis? Yes No

Collaborating/Supervising Physician Name (Print) Date:

Signature: _____ Date: