

**PUBLIC HEALTH DIVISION
CLINICAL PROTOCOL/MANUAL APPROVAL SHEET**

PROGRAM/BUREAU: Family Planning Program/ Family Health Bureau

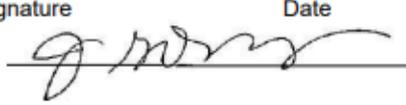
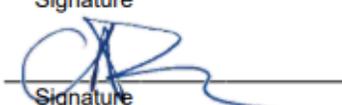
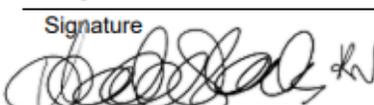
CLINICAL PROTOCOL/MANUAL TITLE: 2021 Family Planning Program Protocol

Location: <https://nmhealth.org/about/phd/fhb/fpp/pvdr>

Reviewed by: (Must have a signature from at least one clinical user of the Protocol)
User Reviews:

Name: <u>Anaya, Ronda, FNP-BC</u>	Date: 9/28/20
Name: <u>Artiglia, Lauren, CNP</u>	Date: 4/27/21
Name: <u>Benon, Robert, FNP</u>	Date: 4/26/21
Name: <u>Bullock, Carletta, MD</u>	Date: 4/20/21
Name: <u>Duran, Leo, Pharmacist</u>	Date: 3/8/21
Name: <u>Garrison, Susan, CNP</u>	Date: 9/29/20
Name: <u>Griffin, Emily, CNP</u>	Date: 2/22/21
Name: <u>Martinez, Maria, FNP-C</u>	Date: 8/18/21
Name: <u>Ogren, John, MD</u>	Date: 4/12/21
Name: <u>Perea, Margaret, Clerk Specialist</u>	Date: 2/5/21
Name: <u>Pinales, Maria, RN-BSN</u>	Date: 8/18/21
Name: <u>Singh, Rameet, MD</u>	Date: 3/11/21
Name: <u>Tivis, Barbara, Clerk Specialist</u>	Date: 2/4/21
Name: <u>Vela, Beatriz, RN-BSN</u>	Date: 8/18/21

Approved by:

FPP Medical Director:	<u>Amanda Goertz</u> Print	Amanda Goertz <small>Digitally signed by Amanda Goertz Date: 2021.06.04 09:20:53 -0600</small> Signature _____ Date _____
FPP Program Manager:	<u>Susan Lovett</u> Print	<u>Susan Lovett</u> <small>Digitally signed by Susan Lovett Date: 2021.06.21 11:18:07 -06'00'</small> Signature _____ Date _____ 
FHB Bureau Chief:	<u>Janis Gonzales</u> Print	Signature _____ Date _____
PHD Medical Director:	<u>Chris Novak</u> Print	 Signature _____ Date <u>06/09/21</u>
Regional Health Officer:	<u>Eugene Marciniak</u> Print	<u>Eugene Marciniak, MD</u> Signature _____ Date <u>06/25/2021</u>
PHD Chief Nurse:	<u>Heather Black</u> Print	 Signature _____ Date <u>06/21/21</u>

**PUBLIC HEALTH DIVISION
ACKNOWLEDGEMENT AND RECEIPT OF NEW/REVISED CLINICAL
PROTOCOL**

PROGRAM: Family Planning Program

CLINICAL PROTOCOL/MANUAL TITLE: 2021 Family Planning Program Protocol

I have reviewed the document listed above and I approve it for practice in Region _____

Regional Director Date

Regional Health Officer Date

Regional Director of Nursing Service Date

Regional Director of Nursing Service Date

I have received, reviewed and will follow this Clinical Protocol and its Standing Orders.

Staff (Clinicians, PHNs, Clerks etc.):

_____ Name	_____ Date	_____ Name	_____ Date
_____ Name	_____ Date	_____ Name	_____ Date
_____ Name	_____ Date	_____ Name	_____ Date
_____ Name	_____ Date	_____ Name	_____ Date
_____ Name	_____ Date	_____ Name	_____ Date
_____ Name	_____ Date	_____ Name	_____ Date
_____ Name	_____ Date	_____ Name	_____ Date
_____ Name	_____ Date	_____ Name	_____ Date

Each clinician and PHN must review the document mentioned above and sign this sheet. (Use additional sheets as necessary.) The Nurse Manager will retain the signed copy(ies) of this sheet at the clinic and submit the original(s) to the Director of Nursing Services.