



Pain Clinic License Number: _____

Date Issued: _____

APPLICATION ADD/CHANGE TO LICENSED PAIN CLINIC

FEE INFORMATION

Remit check, or money order made payable to Georgia Composite Medical Board.

- Fee** - \$75.00 - Add a Practicing Physician
- Fee** - \$75.00 - Add a Physician Assistant
- Fee** - \$75.00 - Add a APRN
- Fee** - \$ 0.00 - Add a Managing Employee

If you are adding more than one practicing physician, physician assistant or APRN, a \$75 fee is required for EACH addition.

NOTE: Approval is required in ADVANCE of any new healthcare practitioner working in a licensed pain clinic.

SECTION I: PAIN MANAGEMENT CLINIC - OFFICE INFORMATION

Corporate or Legal Name of Pain-Management Clinic:

Doing Business As Name:

Federal Tax Identification Number (FEI#) OR Employer Identification Number:

Pain-Management Clinic Physical Address: (P.O. Boxes are not acceptable)

(Street)

(Suite #)

(City)

State

(Zip Code)

(County)

Mailing Address:

(Street)

(Suite #)

(City)

State

(Zip Code)

(County)

Pain Management Clinic Telephone Number: _____

Pain Management Clinic Fax Number: _____

Pain Management Clinic Email Address: _____

1

2. Person to be contacted for communication, or notice and citation matters:

Name: _____ Title: _____

Address: _____

Phone #: (____) ____-____

EMAIL ADDRESS: _____

add managing employee

delete managing employee

Managing Employee Name:	License Number/Profession:
Address:	
Telephone Number:	
DEA Number:	Email Address:

add managing employee

delete managing employee

Managing Employee Name:	License Number/Profession:
Address:	
Telephone Number:	
DEA Number:	Email Address:

AFFILIATED PERSONNEL INFORMATION: Complete the section below for each practicing physician who will be employed at the clinic. If you have more than two practicing physicians working in your clinic, copy this sheet and list the information.

1. Practicing Physician Name:	
License Number/Profession:	
Address:	
Telephone Number:	
DEA Number:	Email Address:

Hours Designated Physician Present in Clinic:

___ add practicing Physician
 ___ delete practicing Physician
 ___ revise hours

Monday	___: ___am/pm to ___: ___am/pm
Tuesday	___: ___am/pm to ___: ___am/pm
Wednesday	___: ___am/pm to ___: ___am/pm
Thursday	___: ___am/pm to ___: ___am/pm
Friday	___: ___am/pm to ___: ___am/pm
Saturday	___: ___am/pm to ___: ___am/pm
Sunday	___: ___am/pm to ___: ___am/pm

Does the practicing physician listed above currently work at any other pain clinic? ___ YES ___ NO

If Yes, list pain clinic name: _____

Pain Clinic Location: _____

2. Practicing Physician Name:	
License Number/Profession:	
Address:	
Telephone Number:	
DEA Number:	Email Address:

Hours Designated Physician Present in Clinic:

___ add practicing Physician
 ___ delete practicing Physician
 ___ revise hours

Monday	___: ___am/pm to ___: ___am/pm
Tuesday	___: ___am/pm to ___: ___am/pm
Wednesday	___: ___am/pm to ___: ___am/pm
Thursday	___: ___am/pm to ___: ___am/pm
Friday	___: ___am/pm to ___: ___am/pm
Saturday	___: ___am/pm to ___: ___am/pm
Sunday	___: ___am/pm to ___: ___am/pm

Does the practicing physician listed above currently work at any other pain clinic? ___ YES ___ NO

If Yes, list pain clinic name: _____

Pain Clinic Location: _____

AFFILIATED PERSONNEL INFORMATION: Complete the section below for the physician assistant who will be employed at the clinic. If you have more than one physician assistant working in your clinic, copy this sheet and list the information.

Physician Assistant Name:	
License Number/Profession:	
Address:	
Telephone Number:	
DEA Number:	Email Address:
Supervising Physician Name:	
Supervising Physician License Number:	

Hours Physician Assistant Present in Clinic:

<input type="checkbox"/> add physician assistant <input type="checkbox"/> delete physician Assistant <input type="checkbox"/> revise hours		Monday	___: ___am/pm to ___: ___am/pm
		Tuesday	___: ___am/pm to ___: ___am/pm
		Wednesday	___: ___am/pm to ___: ___am/pm
		Thursday	___: ___am/pm to ___: ___am/pm
		Friday	___: ___am/pm to ___: ___am/pm
		Saturday	___: ___am/pm to ___: ___am/pm
		Sunday	___: ___am/pm to ___: ___am/pm

Does the physician assistant listed above currently work at any other pain clinic? ___ YES ___ NO

If Yes, list pain clinic name: _____

Pain Clinic Location: _____

Complete the section below for the APRN who will be employed at the clinic. If you have more than one APRN working in your clinic, copy this sheet and list the information.

APRN Name:	
License Number/Profession:	
Address:	
Telephone Number:	
DEA Number:	Email Address:
Delegating Physician Name:	
Delegating Physician License Number:	

Hours APRN Present in Clinic:

<input type="checkbox"/> add APRN <input type="checkbox"/> delete APRN <input type="checkbox"/> revise hours		Monday	___: ___am/pm to ___: ___am/pm
		Tuesday	___: ___am/pm to ___: ___am/pm
		Wednesday	___: ___am/pm to ___: ___am/pm
		Thursday	___: ___am/pm to ___: ___am/pm
		Friday	___: ___am/pm to ___: ___am/pm
		Saturday	___: ___am/pm to ___: ___am/pm
		Sunday	___: ___am/pm to ___: ___am/pm

Does the APRN listed above currently work at any other pain clinic? ___ YES ___ NO

If Yes, list pain clinic name: _____

Pain Clinic Location: _____

