Georgia Composite Medical Board Use Only	
Temporary #: _____	File Number: _____
Date Issued: _____	License Number: _____
	Date Issued: _____

PAIN MANAGEMENT CLINIC
REQUEST TO CHANGE NAME OR LOCATION

FEE INFORMATION:

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

- ❑ **Fee** - $ 25.00 : Change in Name for Pain Management Clinic
- ❑ **Fee** - $125.00: Change in Location for Pain Management Clinic

NOTE: No application will be processed without the application fee. All fees are non-refundable and subject to change.

NOTE: Pain management clinic licenses **are non-transferable. If you have a Change in Ownership, Name or Location you MUST receive approval from the Board. Also, approval is required in ADVANCE of any new healthcare practitioner working in the pain clinic.**

SECTION I: PAIN MANAGEMENT CLINIC - OFFICE INFORMATION

CURRENT NAME OF PAIN CLINIC:

_____

NEW NAME OF PAIN CLINIC:

_____

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

_____

CURRENT PHYSICAL ADDRESS OF PAIN CLINIC: ***(P.O. Boxes are not acceptable)***

_____

(Street) (Suite #)

_____

(City) State (Zip Code) (County)

NEW PHYSICAL ADDRESS OF PAIN CLINIC:

_____

(Street) (Suite #)

_____

(City) State (Zip Code) (County)

Pain Management Clinic Telephone Number: _____

Pain Management Clinic Fax Number: _____

Pain Management Clinic Email Address: _____

SECTION I: PAIN MANAGEMENT CLINIC - OFFICE INFORMATION (con't)

1. List the business operating hours.

Business Operating 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

1a. Clinic accepts the following form(s) of payment for services rendered: **(CHECK ALL THAT APPLY)**

Cash _____YES _____NO
Cash Only _____YES _____NO
Medicaid _____YES _____NO
Medicare _____YES _____NO
Credit Card _____YES _____NO
Private Insurance: _____YES _____NO

Other:_____

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

Name: _____Title: _____

Address: _____

Phone #: (____) _____-_____

EMAIL ADDRESS: _____

3. Type of drugs you wish to dispense:
( ) Prescription Drugs (Other than controlled substances)
( ) Controlled Substances

4. Do you understand that every pain management clinic registered with the Georgia Composite Medical Board is required to submit reports of excessive purchases of controlled substances with the Federal Drug Enforcement Administration and shall be required to submit a copy of each report to the Georgia Drugs and Narcotics Agency?
( ) Yes ( ) No

5. If you currently dispense, name of practitioner under you who will dispense or identify the pharmacist license number.

Name: _____

Pharmacist License Number:_____

SECTION II: PAIN MANAGEMENT CLINIC OWNERSHIP INFORMATION

1. Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation
2. Percentage of Ownership by Georgia physician: _____

   If you are **NOT** 100% physician owned, circle below to indicate which exemption you fall under.

   A. Pain management clinic **jointly owned** by one or more physician assistants or advanced practice registered nurses and one or more physicians?

   B. Pain management clinic **NOT majority owned** by physicians licensed in this state?
3. State of Incorporation: _____
   (If Applicable)
4. List the names and addresses of any and all pain-management clinic owner(s), principal(s), officer(s), agent(s), managing employee(s). **NOTE:** IF YOU HAVE MORE THAN ONE OWNER, PRINCIPAL, OFFICER, AGENT AND/OR MANAGING EMPLOYEE, **use additional sheets to list the information.**

Owner Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Principal Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Officer Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Agent Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

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:

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:

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:

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:

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: _____