



Temporary #: \_\_\_\_\_ File Number: \_\_\_\_\_

Date Issued: \_\_\_\_\_ License Number: \_\_\_\_\_

Date Issued: \_\_\_\_\_

## APPLICATION PAIN MANAGEMENT CLINIC REGISTRATION

**FEE INFORMATION** - Remit check, or money order made payable to:  
Georgia Composite Medical Board.

- Fee** - \$500.00: Initial Administration Registration for Pain Management Clinic
- Fee** - \$125.00: Change in Location for Pain Management Clinic
- Fee** - \$ 25.00 : Change in Name 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

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: \_\_\_\_\_

**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.**

<b>Owner Name:</b>	<b>License Number/Profession:</b>
Address:	
Telephone Number:	
DEA Number:	Email Address:

<b>Principal Name:</b>	<b>License Number/Profession:</b>
Address:	
Telephone Number:	
DEA Number:	Email Address:

<b>Officer Name:</b>	<b>License Number/Profession:</b>
Address:	
Telephone Number:	
DEA Number:	Email Address:

<b>Agent Name:</b>	<b>License Number/Profession:</b>
Address:	
Telephone Number:	
DEA Number:	Email Address:

<b>Managing Employee Name:</b>	<b>License Number/Profession:</b>
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.**

<b>1. Practicing Physician Name:</b>	
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: \_\_\_\_\_

<b>2. Practicing Physician Name:</b>	
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: \_\_\_\_\_

## SECTION III: OWNER QUESTIONNAIRE

EVERY OWNER, PRINCIPAL, OFFICER AND AGENT MUST COMPLETE THE OWNER QUESTIONNAIRE. ALL YES ANSWERS MUST BE SUPPORTED WITH DOCUMENTATION AND EXPLANATION.		YES	NO
1.	Are you a US Citizen?		
2.	Do you own more than one pain management clinic? (If yes, submit a copy of your current license at pain management clinic).		
2a.	Do you have, or ever had, another pain management clinic in another state? If yes, list the state(s).  _____		
3.	Has the clinic ever had the license revoked or otherwise disciplined by a state or federal agency?		
4.	During the last 7 years, have you suffered from any physical, psychiatric, or substance use disorder that could impair or require limitations on your functioning as a professional or has resulted in the inability to practice for more than 30 days, or required court-ordered treatment or hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board)		
5.	Have you ever been convicted of a felony, entered a plea bargain, been arrested, indicted or convicted for violating any state or federal law including DUI (excluding minor traffic violations)? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding, or the affording of Frist Offender Treatment, regardless of whether the adjudication of guilt or sentence is withheld or not entered. If yes, provide a personal narrative of the circumstances surrounding the incident and include a copy of the charges, plea or jury verdict, and final disposition, sentence, probation, and payment of fines		
6.	Has any licensing Board or other state or federal agency ever taken a <b>public or private</b> disciplinary action against you?		
7.	Have you ever been refused renewal of a certificate or a license by any licensing Board or other state or federal agency?		
8.	Are you currently registered with the DEA?		
9.	Have you ever been denied a DEA registration number?		
10.	Have you ever been issued a restricted DEA registration?		

<b>SECTION III: OWNER QUESTIONNAIRE - (con't)</b>		<b>YES</b>	<b>NO</b>
11.	Have you ever surrendered a DEA registration or controlled substance registration?		
12.	Have you ever had your federal registration to prescribe, distribute, or dispense controlled substances suspended or revoked?		
13.	Have you ever been convicted of a crime under any state or federal law relating to any controlled substance? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding or the affording of First Offender Treatment, regardless of whether the adjudication of guilt or sentence is withheld or not entered.		
14.	Have you ever surrendered a medical license?		
15.	Have you ever been, or currently the subject of an investigation by any licensing Board or other state or federal agency?		
16.	Do you currently have any applications for a pain management clinic license pending before any other licensing Board or agency?  If yes, list licensing Board or agency: _____		
17.	Have you ever had any restrictions or been terminated as a Medicaid or Medicare provider in any state? If yes, provide documentation to indicate that you were reinstated and in good standing with the Medicaid Program.		
18.	Are you currently in default on a state or federally funded and/or guaranteed school loan?		
19.	Are you currently in default on child support payments?		

I acknowledge and state that I have read the instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Medical Practice Act and the Board Rules. This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that pursuant to the Official Code of Georgia Annotated, Section 43-34-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application shall be guilty of a felony and upon conviction thereof, shall be punished by a fine of not less than \$500.00 nor more than \$1,000.00, or by imprisonment from two to five years, or both.

\_\_\_\_\_  
Printed Name of Applicant:

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

