



Georgia Composite Medical Board Use Only

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 - \$250.00:** Change of Ownership 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**, you **MUST submit a new application**.

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 and hours in which a physician or other healthcare professional is present in the clinic.

Business Operating Hours:

Hours Designated Physician Present in Clinic:

Monday	____:____ am/pm to ____:____ am/pm	____:____ am/pm to ____:____ am/pm
Tuesday	____:____ am/pm to ____:____ am/pm	____:____ am/pm to ____:____ am/pm
Wednesday	____:____ am/pm to ____:____ am/pm	____:____ am/pm to ____:____ am/pm
Thursday	____:____ am/pm to ____:____ am/pm	____:____ am/pm to ____:____ am/pm
Friday	____:____ am/pm to ____:____ am/pm	____:____ am/pm to ____:____ am/pm
Saturday	____:____ am/pm to ____:____ am/pm	____:____ am/pm to ____:____ am/pm
Sunday	____:____ am/pm to ____:____ am/pm	____:____ am/pm to ____:____ am/pm

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).– **use additional sheets of paper if necessary.**

Owner(s):

Name _____
License Number/Profession _____
Address _____
Address _____
Telephone Number _____
DEA Number _____
Email Address _____

Principal(s):

Name _____
License Number/Profession _____
Address _____
Address _____
Telephone Number _____
DEA Number _____
Email Address _____

Officer(s):

Name _____
License Number/Profession _____
Address _____
Address _____
Telephone Number _____
DEA Number _____
Email Address _____

Agent(s):

Name _____
License Number/Profession _____
Address _____
Address _____
Telephone Number _____
DEA Number _____
Email Address _____

Managing Employee(s)

Name _____
License Number/Profession _____
Address _____
Address _____
Telephone Number _____
DEA Number _____
Email Address _____

AFFILIATED PERSONNEL INFORMATION: List the names and addresses of any and all pain-management clinic practicing physician(s), physician assistant(s), and advance practice register nurses(s).– **use additional sheets of paper if necessary.**

Practicing Physician(s)

Name _____
License Number/Profession _____
Address _____
Address _____
Telephone Number _____
DEA Number _____
Email Address _____

Physician Assistant

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

APRN

Name _____
License Number/Profession _____
Address _____
Address _____
Telephone Number _____
DEA Number _____
Delegating Physician Name _____
Delegating Physician License Number _____
Email Address _____

SECTION III: OWNER QUESTIONNAIRE

EVERY OWNER 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 public or private 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?		

SECTION III: OWNER QUESTIONNAIRE - (con't)		YES	NO
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

SECTION IV: PERSONNEL CERTIFICATION FORM

INSTRUCTIONS:

A. This form should be completed by each **owner** named in the application, and the individual who is the company's contact person **and the managing employee**.

All information requested on this form is mandatory. Failure to provide any and all of the requested information will result in an incomplete background investigation and rejection of the application. This information will be used to determine your qualifications for registration and licensure. This information may be shared with other government agencies upon receipt of an official request.

APPLICANT NAME: _____

SEX: **MALE** **FEMALE**

STREET ADDRESS: _____

City **State** **Zip Code**

Date of Birth: _____

Social Security Number: _____

Telephone: _____

Fax: _____

Firm Name: _____

Position with the Firm: _____

Print or type name: _____

Signature: _____

Date: _____

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any license issued may be in force and effect.

Firm Name: _____

Individual Name: _____

Applicant Signature _____

By: _____
(State whether individual Owner, Partner or officer of the corporation)

Date: _____