Pain Clinic License Number: _____

Date Issued: _____

PAIN CLINIC APPLICATION
ADD, DELETE, REVISE PAIN CLINIC INFORMATION

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

- ❑ **Fee** - $75.00 - **Add** Practicing Physician
- ❑ **Fee** - $75.00 - **Add** Physician Assistant
- ❑ **Fee** - $75.00 - **Add** APRN
- ❑ **Fee** - $75.00 - **Add** Managing Employee

____ **Fee: $0.00** Revise Hours of Practicing Physician
____ **Fee: $0.00** Revise Hours of Physician Assistant
____ **Fee: $0.00** Revise Hours of APRN
____ **Fee: $0.00** Revise Business Hours

____ **Fee:** $0.00 **Delete** Practicing Physician
____ **Fee:** $0.00 **Delete** Physician Assistant
____ **Fee:** $0.00 **Delete** APRN
____ **Fee:** $0.00 **Delete** Managing Employee

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

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. List the business operating hours.

__Revise BUSINESS HOURS
LIST THE <u>REVISED</u> HOURS YOU ARE REQUESTING IN THE MONDAY-SUNDAY SECTIONS.

EFFECTIVE DATE:

_____

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

LIST THE <u>CURRENT APPROVED</u> <u>BUSINESS OPERATING HOURS HERE:</u>

_____

_____

_____

_____

_____

_____

_____

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

Name: _____Title: _____

Address: _____

Phone #: (____) _____-_____

EMAIL ADDRESS: _____

___add managing employee

EFFECTIVE DATE: _____

___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 <u>more than one practicing physician who you wish to add to your clinic,</u> copy this sheet.

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

___add practicing physician

___delete practicing physician

___revise hours of practicing physician

EFFECTIVE DATE:

_____

Hours Practicing 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

IF YOU ARE <u>REVISING</u> THE HOURS, <u>LIST THE CURRENT APPROVED HOURS FOR THIS PHYSICIAN HERE</u>:

_____

_____

_____

_____

_____

_____

_____

Does the practicing physician listed above currently work at any other pain clinic? ____YES___NO
(This includes any pain clinic location, **other than the one identified on page 1**, even if it is one of your other locations)

1. If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

2. If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

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 who you wish to add to your clinic, copy this sheet.

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

___add physician assistant

___delete physician assistant

___revise hours of physician assistant

EFFECTIVE DATE:

_____

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

IF YOU ARE REVISING THE HOURS, LIST THE CURRENT APPROVED HOURS FOR THIS PHYSICIAN ASSISTANT HERE:

_____

_____

_____

_____

_____

_____

_____

Does the physician assisted listed above currently work at any other pain clinic? ____**YES**___**NO**
(This includes any pain clinic location, **other than the one identified on page 1**, even if it is one of your other locations)
If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

A. Will the physician assistant be prescribing controlled substances for this location? ___YES __NO

B. If yes, does the physician assistant have an approved job description for this location? ___YES __NO

Complete the section below for the APRN who will be employed at the clinic. If you have more than one APRN who you wish to add to your clinic, copy this sheet.

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

___add APRN

___delete APRN

___revise hours of APRN

EFFECTIVE DATE:

_____

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

IF YOU ARE REVISING THE HOURS, LIST THE CURRENT APPROVED HOURS FOR THIS APRN HERE:

_____

_____

_____

_____

_____

_____

_____

Does the APRN listed above currently work at any other pain clinic? ____**YES**___**NO**
(This includes any pain clinic location, **other than the one identified on page 1**, even if it is one of your other locations)

If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

A. Will the APRN be prescribing controlled substances for this location? _____YES ____NO

B. If yes, does the APRN have an approved physician protocol agreement for this location? ___YES ___NO

SECTION IV: PERSONNEL CERTIFICATION FORM

INSTRUCTIONS:

This form should be completed by each **OWNER, PRINCIPAL, OFFICER, AGENT, MANAGING EMPLOYEE AND LICENSED HEALTH CARE PRACTITIONERS** named in the application.

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 to work in a pain clinic. This information may be shared with other government agencies upon receipt of an official request.

NAME: _____

SEX: ____**MALE** _____**FEMALE**

STREET ADDRESS: _____

_____

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

Date of Birth: _____

Social Security Number: _____

Telephone: _____

Fax: _____

Pain Clinic Name: _____

Position with the Pain Clinic: (check below all those that apply)

____Owner ____Principal ____Officer ____Agent
____Managing Employee ____Practicing Physician ____Physician Assistant ____APRN

____**Other:**_____

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.

Print Name: _____

Applicant Signature: _____

Date: _____