Georgia Composite Medical Board
http://www.medicalboard.georgia.gov
2 Peachtree St., N.W., 36th Floor
Atlanta, Georgia 30303
Tel: 404.656.3913
Fax: 404.656.9723

Log in any time to check your application status* at http://tinyurl.com/MedicalBoardLogin*. Or scan here:

Initial Physician Licensure (Graduate of Medical School Outside U.S. and Canada) Applicants Applying by Mail

Thank you for submitting your application! Within 7 business days after we have received your completed application and payment, your Applications Specialist will review your application and update your online checklist. You can use this checklist and the attached forms to get started now. If you have a GCMB Online account, you can log in to check your updated application status online any time, day or night. If you do not have a GCMB Online account, ask us to create one for you. **(Note: If you have already sent some or all of these documents to us, you may not need to send them again.)**

Submit the following items to us as soon as possible. They are required of all applicants.

- ☐ **Application and Application Fee ($500.00)**
- ☐ **Your current CV or resume** (also, provide information for any date gaps in the CV or resume)
- ☐ **Form B**, Reference Form (three references are required)
- ☐ **Form D**, Affidavit of Applicant
- ☐ **Form D2**, Affidavit for Medical Board License
- ☐ **A copy of a secure and verifiable document** from the list following Form G
- ☐ **Form E**, Malpractice Questionnaire, including documentation of any cases

Submit the following items if you are not using Federation Credentials Verification Service (http://www.fsmb.org/fcvs.html).
FCVS users: You do not need to send us these items. They will be provided to the Board by FCVS.

- ☐ **Official medical transcript**, issued to the Georgia Composite Medical Board. We must receive this either directly from the school, or in an unaltered, unopened, sealed envelope. If it is not in English, include a certified copy of English translation.
- ☐ **Official licensing examination score transcript**, issued to the Georgia Composite Medical Board. We must receive this directly from the agency providing the transcript or report. You can order USMLE and other national exam score transcripts at http://www.fsmb.org/transcripts.html.
- ☐ **Copy of ECFMG Certificate.** If you were licensed by another state before March 1, 1958, you may submit proof of succesful completion of AMA-approved Fifth Pathway Program and ECFMG medical component instead.
- ☐ **Form A**, Certificate of Postgraduate Training, for each training program you have participated in. We must receive this either directly from the school, or in an unaltered, unopened, sealed envelope.

Submit the following items, if applicable. ***(Note: Some circumstances may require items not listed here.)***

- ☐ **National Practitioner Data Bank (NPDB) and Health Integrity and Protection Data Bank (HIPDB) Self-Query and Reports**, if you have ever held a license in the US or Canada (not including training licenses). Order it at https://www.npdb-hipdb.hrsa.gov/ext/RulesOfBehaviorSQ.jsp?SUBJECT_TYPE=I.
- ☐ **Official license verification** from each state, territory, or province of the U.S. or Canada in which you have held any type of medical license, including training, limited, or restricted licenses. We must receive this directly from the licensing authority or from Veridoc (www.veridoc.org). Contact information for other licensing authorities can be found at http://www.fsmb.org/directory_smb.html.
- ☐ **Military discharge documentation**, if you have ever been discharged from US military service.
- ☐ **Explanations and documentation** concerning any arrests, convictions, disciplinary actions, licensure denials, etc.
- ☐ **Form G,** Specific Power of Attorney, if you want to authorize anyone else to make inquiries about your application.

If your last name starts with:	*Your Applications Specialist is:*	*Contact details:*
A through G	Katonya Reynolds	404-463-6162; kreynolds@dch.ga.gov
H through O	Candis Dickerson	404-657-6491; cdickerson@dch.ga.gov
P through Z	Deborah Bruce	404-656-7067; dbruce@dch.ga.gov

Licensure Unit Manager: Carol Dorsey (404-651-7854; cdorsey@dch.ga.gov)

Georgia Composite Medical Board Use Only

Temporary #: _____ File Number: _____

Date Issued: _____ License Number: _____

Date Issued: _____

☐ **Check this box if you are applying for an Administrative License (non-clinical practice).**

Initial Physician Application

All fees are nonrefundable and subject to change.

Name and Personal Detail

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. §651 and 20 U.S.C.A. § 1001. This information may also be disclosed to the National Practitioner Data Bank or other state medical boards or regulatory agencies for license tracking purposes.

Social Security Number _____

Last Name (Surname) _____

First _____

Middle _____

Other Surnames _____

Degree ☐ MD ☐ DO Specialty _____

Gender ☐ Male ☐ Female

Birth Date (mm/dd/yy) _____

Contact Detail Summary

General Addresses

Mailing Address: Correspondence from the Board is sent to this address. Email address is utilized by the Board to contact you in case of an emergency situation. This address will not appear on the Internet *unless you **fail** to provide a practice location address.*

_____

Street Number Street Name City St ZIP Apt

_____

Area Code Phone Number Email _____

Practice Location/Administrative Office Location: Posted on the Internet when the license number is issued.
Your mailing address will appear on the Internet if you do not provide a practice/office location!!

_____

Street Number Street Name City State ZIP Suite/Bldg

_____

Area Code Phone Number

Applicant Questionnaire:

"Yes" responses require a personal explanation and supporting documentation.

	YES	NO
1.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 medicine 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. **NOTE: If you are currently enrolled in GAPHP, you may check NO.**	☐	☐
2. Have you 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, regardless of whether the adjudication of guilt or sentence is withheld or not entered.	☐	☐
3. Have you ever been denied the privilege of taking an examination given by any licensing Board or Agency?	☐	☐
4. Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?	☐	☐
5. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	☐	☐
6. Have you ever been denied a DEA registration number?	☐	☐
7. Have you ever been issued a restricted DEA registration?	☐	☐
8. Are you currently registered with the DEA?	☐	☐
If yes, provide DEA number_____ and State of Issue _____		
9. Have you ever been named as a party in a malpractice suit, arbitration hearing, State Review panel proceeding, or a VA/Federal agency review?	☐	☐
10. Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you?	☐	☐
11. Have you ever been denied membership in, or in any way sanctioned, by any medical or osteopathic association, society, or specialty society?	☐	☐
12. Have you ever surrendered a medical license?	☐	☐
13. Have you ever surrendered a controlled substance registration?	☐	☐
14. Have you ever surrendered a DEA registration?	☐	☐
15. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	☐	☐
16. Do you have any applications for licensure pending before any other licensing Board or agency? If yes, provide a list.	☐	☐
17. Have you ever had any restrictions as a Medicaid or Medicare provider?	☐	☐
18. Are you in default on a state or federally funded and/or guaranteed school loan?	☐	☐
19. Are you in default on child support payments?	☐	☐
20. Do you intend to practice medicine in Georgia? Please provide your plans below:	☐	☐

Program Questions

1. What examinations have you taken? ☐ USMLE ☐ NBME ☐ COMLEX ☐ ________State Board (Specify) Structured Examination ☐ LMCC ☐ FLEX ☐ NBOME

2. How long have you lived in the US? ______years _____months

3. Have you served in the U.S. Armed Forces? If yes provide a copy of Military Discharge Paperwork ☐ Yes ☐ No

4. Are you Board certified in your specialty? ☐ Yes ☐ No
If yes, provide specialty ________________________________

5. Will you be using FCVS? ☐ Yes ☐ No

6. Are you a US Citizen? ☐ Yes ☐ No

If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. **Only those applicants who can provide proof will be granted a license.** The Board participates in the **DHS-USCIS SAVE** (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens. In order to confirm your status with the SAVE program, you need to provide the board with **legible** copies of **one** of the documents on the enclosed list.

License History

Provide history for each permanent, temporary, training, provisional, or limited licensed obtained in any state in the US, Canadian Territory or Province, or US Federal Jurisdiction.

State __________ **Country** ________________________ **Status** ____________________
Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ________________________ **Status** ____________________
Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ________________________ **Status** ____________________
Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ________________________ **Status** ____________________
Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ________________________ **Status** ____________________
Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ________________________ **Status** ____________________
Issued From: (mm/dd/yy) To: (mm/dd/yy)

License History (continued)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

REVISED: 8/2013

Medical/Osteopathic Education

Pre-medical Education

Beginning month and ending year for each year of attendance is required.

College _____

1st. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
2nd. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
3rd. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
4th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
5th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
6th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
7th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
8th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
9th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)

Medical Education

Beginning month and ending year for each year of attendance is required.

Medical School _____

1st. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
2nd. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
3rd. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
4th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
5th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
6th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
7th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
8th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
9th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)

Post Graduate Training

Specialty _____

Hospital _____

Address _____

City/State/Zip _____

Specialty _____

Hospital _____

Address _____

City/State/Zip _____

Attach more pages if you have more to list.

Hospital Privileges

Have you ever held any hospital privileges? ☐ Yes ☐ No

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Attach more pages if you have more hospitals to list

FORM A

CERTIFICATE OF POSTGRADUATE TRAINING

INSTRUCTIONS: To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Either the hospital seal OR notary seal must be on this form. Errors shall be noted by one line through the error and initials of correcting party. No whiteouts or strikeouts are acceptable on this form and may result in a delay of the application process. This form may be sent with the applicant's application packet only if the original envelope is unopened, and the program director has signed his/her name across the back of the envelope. Altered envelopes which contain official, original, or certified official documents will not be accepted.

PART 1: TO BE COMPLETED BY THE APPLICANT.

Name: _____ Date of Birth: _____ SSN: _____

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR.

Every effort should be made by the training program to complete this form as accurately as possible. However, the Georgia Composite Medical Board does understand that programs close and facilities merge making records unavailable. The Federation of State Medical Boards has offered all Accreditation Council of Graduate Medical Education approved programs which have closed the opportunity to permanently store their resident records. Additionally, a few American Osteopathic Association approved programs and other training programs have sent resident records to the Federation. This will provide a central repository for those entities requiring verification of physicians' credentials.

US and Canadian Medical School Graduates: Please provide the training dates. If the program is in progress, you may provide the "to" date as the date which the training is scheduled to be completed. This will provide the current standing of the training.

International Medical School Graduates: **Do not complete this form unless the training requirement has been completed**. As of February 5, 2010, the Georgia Composite Medical Board voted to utilize the *Medical Schools Recognized by the Medical Board of California* (MSRMBC) as its official reference for approval of medical schools outside the US and Canada. The list may be viewed online at http://www.mbc.ca.gov/applicant/schools.html Graduates are required to complete training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) as follows:

If school is recognized by MSRMBC, one year (1) year
If school is not recognized by MSRMBC, three (3) years

Please print, type or stamp the following information:

Name of Program: _____

Sponsored by: _____

Program ID: _____

Address: _____

City, State, Zip: _____

Affiliated University:

Georgia Composite Medical Board Use Only

AMA _____

AOA _____

RCPSC _____

CFPC _____

It is further certified that this program is accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Council on Postdoctoral Training (ECCOPT), RCPSC, or CFPC for the training of medical and osteopathic interns, residents, fellowships, and research as an Accredited Program, Graduate Medical Education Teaching Institution, or Osteopathic Postdoctoral Training Program. This is to certify that the applicant name in Part 1 has completed, not completed, or the training is in progress as follows:

☐ Internship from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

☐ Residency from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

☐ Chief Residency from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

☐ Fellowship from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

☐ Research from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

If "YES" to any of the following questions, please provide a written explanation and supporting documentation:

Any leave of absences requested/reported?	☐ Yes	☐ No
Any probationary action ever taken?	☐ Yes	☐ No
Any disciplinary actions or investigations?	☐ Yes	☐ No
Any special requirements or limitations due to questions of academic incompetence, disciplinary problem, etc	☐ Yes	☐ No

Completion of this form will certify that the individual named in Part 1 above completed a period of accredited postgraduate training at this facility. This form shall be signed by the Program Director (MD or DO only).

Program Director's Name _____ Notary's Name _____

Signature _____ Date _____ Notary Signature _____

Affix the institutional seal in this space. If you have no seal available, you are required to have this form notarized.

FORM B
REFERENCE FORM – INITIAL PHYSICIAN LICENSURE

To Applicant: The GEORGIA COMPOSITE MEDICAL BOARD requires completion of **three (3)** reference forms, **one** each from licensed physicians who have known you and have been familiar with your practice for more than six months. Formal letters of reference are not accepted in lieu of the Reference Form since questions on the form are required by the Georgia Composite Medical Board. The Program Director or Physician will complete the form and send it directly to **you. Do not open the envelope**; send it with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

Please mail your form with your application packet to:

GEORGIA COMPOSITE MEDICAL BOARD
ATTENTION: PHYSICIAN LICENSURE
2 Peachtree Street, NW 36th Floor
Atlanta, GA 30303

In addition, the forms must meet the following criteria:

a. Sent by a licensed physicians familiar with your practice and who have known you **more than six months**.
b. Original signature and date of signature of reference source.
c. The date of the reference source's signature is **invalid** six months of the date it was signed.
d. It is preferable that one be sent by the Program Director or Chief of Service for those who have recently completed residency training, or the last hospital where staff privileges were held.
e. The Board **does not accept faxed copies of the forms**.

Applicant: Please type or print your name and address below for identification purposes.

NAME OF APPLICANT: _____

ADDRESS: _____

CITY, STATE AND ZIP CODE: _____

To Reference Source: Please complete this form, sign, and return to the **applicant** in a **sealed envelope** at the above stated address. You response is confidential, pursuant to Georgia law. All applicants are required to sign a general release, which relieves anyone of any liability for information furnished in good faith. Please print or type all information. Please make sure the applicant's name is indicated on the form. The Physician should complete the reference form and return it to the **applicant. Sign your name across the back of the envelope.** The processing time for licensure directly depends on timely receipt of critical forms such as this.

ATTENTION: *The person who signs this form **MAY NOT** be related to the applicant by blood, marriage, or adoption.*

THIS POINT FORWARD IS TO BE COMPLETED BY THE REFERENCE SOURCE:

From:

First | Middle Initial | Last | Degree (MD/DO/MBBS)

Address | City | State | Zip

Area code | Phone Number

Area code | FAX Number

1. How long have you known this physician? _____
[years] [months]

2. In what capacity are you acquainted with this physician?

FORM B - CONTINUED
REFERENCE FORM – INITIAL PHYSICIAN LICENSURE

PLEASE CONFIRM THAT THE FOLLOWING RESPONSES ARE CORRECT BEFORE SUBMITTING THIS FORM. INAPPROPRIATE ANSWERS WILL RESULT IN A DELAY IN PROCESSING YOUR APPLICATION.

If you answer "YES" to questions 1-7, please provide an explanation.

	Yes	No
1. Have you ever received reports of poor medical practice by this physician, or have you discussed concerns you had about this physician's practice with medical staff officers at a hospital?	❑	❑
2. Have you ever received reports of poor relationships between this physician and other members of hospital staff?	❑	❑
3. Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	❑	❑
4. Does this physician have, or has this physician had in the past, any mental or physical illnesses or personal problems that interfere with his/her medical practice?	❑	❑
5. Has this physician ever abused alcohol or drugs or shown signs of chemical dependency?	❑	❑
6. Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	❑	❑
7. Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	❑	❑

If you answer "NO" to questions 8-11, please provide an explanation.

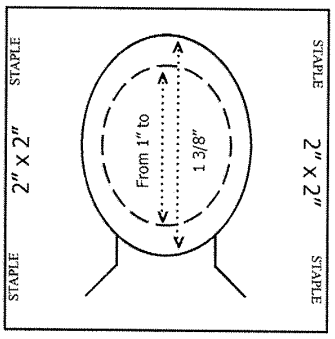
	Yes	No
8. Does this physician accept medical staff and hospital policies and function willingly according to these policies?	❑	❑
9. Does this physician enjoy professional respect among his/her colleagues and in the community where applicant practices?	❑	❑
10. Are you sorry to see this physician leave your community?	❑	❑
11. Do you recommend this physician for unrestricted medical licensure in Georgia?	❑	❑

If you have any comments regarding this applicant, please put your response in writing and attach it to this form. Please sign, provide your title, name of hospital if applicable and the date.

SIGNATURE **TITLE**

HOSPITAL (IF APPLICABLE) **DATE**

Name:_____ **Social Security Number :** _____



Attach Passport Photo Here

FORM D
AFFIDAVIT OF APPLICANT

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application Information and Applicant 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, copies of which are sent to applicants.

I further state that by filing this application for license to practice medicine in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I request and authorize any treatment program to release alcohol and drug abuse patient records to the Georgia Composite Medical Board for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of medical licensure in Georgia.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or International), court, association, institution, or other organization having control of my documents, records and other information pertaining to me, to furnish to the Georgia Composite Medical Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Composite Medical Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

I authorize and request the Georgia Composite Medical Board to obtain any criminal history information concerning me from any authorized law enforcement agency, including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release, discharge, and exonerate the Georgia Composite Medical Board, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite Medical Board.

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 for a license to practice medicine 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.

Applicant's Name: _____ **Application Date:** _____

Date the application was executed; may differ from date this affidavit was notarized

Signature of Applicant: _____

Being duly sworn, says that he/she is the person who executed the application for a license to practice medicine and surgery in the State of Georgia; that all the statements herein contained are true in every respect; and that the attached photo is a true photo of the applicant.

Affix the Notary Seal/Stamp In this space.

Sworn and subscribed to me this _____ day of _____ in the year _____.

Signature of Public Notary: _____

My Commission Expires: _____

O.C.G.A. § 50-36-1(e)(2) Affidavit for Medical Board License - INITIAL APPLICATION ONLY

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, from the Georgia Composite Medical Board, the undersigned applicant verifies **one** of the following with respect to my application for a public benefit:

☐ 1. I am a United States citizen.

☐ 2. I am a legal permanent resident of the United States.

☐ 3. I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security.
My alien number issued by the Department of Homeland Security is: _____.

☐ 4. I am NOT a citizen of the United States, and am NOT physically present in the United States. (See note in instructions below).

I am 18 years of age or older and have provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit. In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____(state).

_____ _____

SIGNATURE OF APPLICANT NAME OF APPLICANT (PRINT)

LICENSE TYPE APPLYING FOR (check one):

☐ 1101 – PHYSICIAN ASSISTANT
☐ 1104 – PHYSICIAN
☐ 1106– RESPIRATORY CARE PROFESSIONAL
☐ 1109 – ACUPUNCTURIST
☐ 1112 – CLINICAL PERFUSIONIST
☐ 1114 – TEMPORARY RESIDENCY TRAINING PERMIT
☐ 1115 – ORTHOTIST
☐ 1116 – PROSTHETIST
☐ 1117 – ORTHOTIST/PROSTHETIST (DUAL)
☐ 1119 – ASSISTANT COSMETIC LASER PRACTITIONER
☐ 1120 – SENIOR COSMETIC LASER PRACTITIONER

☐ OTHER (SPECIFY): _____

INSTRUCTIONS TO APPLICANT:
1. **Be sure to submit the correct type of document with this affidavit.** If you are not a citizen of the United States, you must submit a copy of a document we can use to verify your lawful presence, such as your U.S. Permanent Resident Card, foreign passport with I-94 attached, etc. If you are a U.S. citizen, you may submit a copy of your U.S. passport, driver's license, birth certificate, etc.

2. Mail this original affidavit and a copy of at least one acceptable verifiable document to
GA COMPOSITE MEDICAL BOARD,
2 PEACHTREE ST NW, 36TH FLOOR
ATLANTA GA 30303.

Note: If you checked #4 to indicate that you are not a US citizen and are not physically present in the US, submit the affidavit (without any other document) only.

_____

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE

_____ DAY OF _____, 20____

_____
NOTARY PUBLIC
My Commission Expires:

FORM E
MALPRACTICE QUESTIONNAIRE

INSTRUCTIONS: Complete, sign, and date this Questionnaire. Complete a separate form for each case in which you have ever been named as a defendant, even if you have been dismissed or even if the case is still pending. You must attach the appropriate documentation from the courts and mail it to the Board. Do not take shortcuts on documenting malpractice. You must give a detailed summary of your actual involvement in the treatment of the patient. Failure to do so can result in delays in the processing of your application. Summaries by your attorney or your insurance company are not accepted in lieu of this documentation. The Georgia Composite Medical Board requires a copy of the Plaintiff's Complaint, and either the Settlement Agreement, Dismissal Order or Summary Judgment. Copies can be your own, or obtained either from your attorney or county clerk's office, and must be 8-1/2" by 11" in size. Do not submit two-sided copies.

Full Name of Physician _____ Business Telephone Number _____

Address _____ City _____ State _____ Zip Code _____

☐ **None. If none, please complete information above. Then, sign and date the form and mail it to the Board.**

Name of Patient: _____
Last Name First Name Middle Name

Age of Patient _____ Years

Date of Occurrence: _____

Location of Incident:

Site _____

Address _____

City _____ County _____ State _____ Zip _____

Position in Case: ☐ Intern ☐ Resident ☐ Primary Physician ☐ Other:

Filed Against: ☐ Individual Physician ☐ Group ☐ Hospital

List Names of Other Physicians/Hospitals: _____

Attach to this document a detailed, typewritten summary of the circumstances surrounding the incident and your involvement in your own words. Do not reference other documents – include them with the summary. Even if the incident occurred while you were an intern or resident, a summary must accompany this form.

Disposition: ☐ Pending ☐ Settled ☐ Dismissed

If settled, provide the following information: ☐ In Court ☐ Out of Court Date of settlement: _____

Total Amount of Settlement: $_____ Amount Attributable to you: $_____

******* IMPORTANT: THIS FORM IS INVALID WITHOUT YOUR SIGNATURE AND SIGNATURE DATE. *******

_____
SIGNATURE (REQUIRED) DATE SIGNED

FORM G
SPECIFIC POWER OF ATTORNEY

I, _____, do hereby authorize and direct _____and
Applicant's full name Company or designated agent's name

its agents and employees, by this Specific Power of Attorney to carry out and execute certain duties pursuant to my request and necessary in _____'s reasonable judgment in connection with
Company or designated agent's name

my pursuit of a license to practice medicine in the State of Georgia ("Licensed State").

It is expressly understood and agreed that this Specific Power of Attorney authorizes _____to
Company or designated agent's name

make inquiries as to the status of my application for a medical license in the Licensed State. This Specific Power of Attorney does not authorize _____to act on my behalf for any other purpose
Company or designated agent's name

and shall expire on the date I am granted a license in the Licensed State, the date my application for a medical license is denied, or upon _____'s receipt of written notice from me of
Company or designated agent's name

revocation of this Specific Power of Attorney.

I hereby release _____and the Licensed State from any and all liability,
Company or designated agent's name

damages, claims for damages, suits, actions and causes of action which may accrue as a result of _____acting on my behalf in connection with my pursuit of a medical license
Company or designated agent's name

in the Licensed State.

<table>
<tr><td>_____
PRINTED NAME OF APPLICANT

_____
SIGNATURE OF APPLICANT</td><td colspan="2">Being duly sworn, says that he/she is the person who executed the above application for a license to practice medicine and surgery in the State of Georgia; and that all the statements herein contained are true in every respect.</td></tr>
<tr><td>Sworn and subscribed to me this _____day of _____, _____

_____
(Notary Public)</td><td>My Commission Expires

_____</td><td>NOTARY SEAL MUST BE IMPRINTED HERE</td></tr>
</table>

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2012 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Certification of Report of Birth issued by the United States Department of State (Form DS-1350) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]