Georgia Composite Medical Board Use Only

Temporary #: _____ File Number: _____

Date Issued: _____ License Number: _____

Date Issued: _____

Initial Auricular Detoxification Technician 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 _____

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 State Zip Apt

Area Code Phone Number Email _____@_____

Practice 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 location!!

Street Number Street Name Suite/Bldg City State Zip

Area Code Phone Number

License History

List all states in reverse chronological order that you are/have been licensed to practice as a Auricular Detoxification Technician by virtue of a certification issued by another duly constituted licensing Board in the United States.

State	Date Licensed From (mm/dd/yyyy)	Date Licensed To (mm/dd/yyyy)	License Number	Licensure Status Active/Inactive)

ACUPUNCTURIST APPLICANT QUESTIONNAIRE

	YES	NO
1. Have you passed the NADA Training Program and received certification for the Clean Needle Technique Certification? If you have passed, please contact the NADA and have then send verification of your certification directly to the Georgia Composite Medical Board.	___	___
<u>INSTRUCTIONS</u>: If you answer, "YES" to any of the following questions, you are required to furnish complete details, including an explanation, date, place, offense charged, plea, final disposition of the matter, name of court, state, count/jurisdiction (include any court orders or copies of malpractice suites if applicable).		
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. Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?	___	___
4. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	___	___
5. Have you ever voluntarily surrendered your certification or license?	___	___
6. Has your application for taking a licensing or certification examination ever been denied?	___	___
7. During the last seven years, were you treated for alcohol, mental or physical disorder, chemical drug dependency, neurologic, or psychiatric illness that required outpatient evaluation or inpatient hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board.	___	___
8. Are you a U.S. Citizen? (If no, please refer to the applicant checklist listed on our website for acceptable documentation) 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 listed on our website.	___	___

College Education Information

ONLY LIST COLLEGE OR OTHER EDUCATION. DO NOT INCLUDE AURICULAR DETOXIFICATION EDUCATION OR TRAINING:			
NAME OF SCHOOL			
ADDRESS	CITY	STATE	ZIP CODE
DATE OF GRADUATION			
COURSE OF STUDY (E.G., COLLEGE PREP, ETC.)			

Auricular Detoxification Education and Training Information

PLEASE LIST THE NADA TRAINING PROGRAM(S) YOU HAVE ATTENDED AND/OR RECEIVED TRAINING INCLUDING PROGRAMS NOT LOCATED WITHIN THE UNITED STATES. PLEASE USE ADDITIONAL SHEETS IF NECESSARY.			
NAME OF SCHOOL:			
ADDRESS	CITY	STATE	ZIP CODE
DATES OF ATTENDANCE		GRADUATION DATE:	
SPECIALTY (IF ANY)			
NAME OF SCHOOL:			
ADDRESS	CITY	STATE	ZIP CODE
DATES OF ATTENDANCE		GRADUATION DATE:	
SPECIALTY (IF ANY)			
NAME OF SCHOOL:			
ADDRESS	CITY	STATE	ZIP CODE
DATES OF ATTENDANCE		GRADUATION DATE:	
SPECIALITY (IF ANY)			

Work History: Auricular Detoxification

APPLICANTS: Please complete your work history only as it relates to the practice of auricular detoxification. For non-auricular detoxification related employment, please list the employer, dates employed, and job title. DO NOT list your job duties. **PLEASE USE ADDITIONAL SHEETS IF NECESSARY.**

Date Form Completed: __ __ / __ __/ __ __ __ __

1. LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME	DEGREE (MD OR DO)

	SEX M F	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YY)
		__ __ __ - __ __ - __ __ __ __	__ __ / __ __/ __ __ __ __ CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

STREET NUMBER	STREET NAME	APARTMENT #

CITY	STATE	ZIP CODE	COUNTY

2. RECORD WORK HISTORY CHRONOLOGICALLY – Complete Work History beginning with present employment and concluding with graduation. You must account for all breaks in work history, including, volunteer work and periods of unemployment. If the work was not related to the practice of auricular detoxification, please list only the name of the business, job title and dates worked. DO NOT list your description of job duties for non-ADT related jobs.

E-MAIL ADDRESS

A. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	
TOTAL TIME WORKED _____/_____ MONTH YEAR	**APPROXIMATE NUMBER OF PATIENTS:_____** **APPROXIMATE NUMBER OF PATIENT VISITS:_____**	

B. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	
TOTAL TIME WORKED _____/_____ MONTH YEAR	**APPROXIMATE NUMBER OF PATIENTS:_____** **APPROXIMATE NUMBER OF PATIENT VISITS:_____**	