Georgia Composite Medical Board Use Only

Temporary #: _____ File Number: _____
Date Issued: _____ License Number: _____
Date Issued: _____

Initial Orthotist & Prosthetist Application

All fees are nonrefundable and subject to change.

Application Category: Please check one or more of the boxes below:

I would like to apply for licensure for:	**Based on:**
____ Orthotist ____ Prosthetist ____ Orthotist/Prosthetist **I currently hold the following license in: (Check one)** **____Orthotics _____Prosthetics**	**____ Baccalaureate degree** **____ Associates degree** **Current license #:_____** **Date license issued:_____**
I would like to upgrade to a: ____ Orthotist ____ Prosthetist **____ Orthotist/Prosthetist**	

NOTE: The term of the license "upgrade" will coincide with the "original" licensure and renewal of both to occur at the same time.

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 Degree:_____

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 City State Zip Suite/Bldg

Area Code Phone Number Email @

License History

INSTRUCTIONS: If you are now or have ever been licensed to practice as an Orthotist or Prosthetist in another state, original verifications of license history certification is required for each permanent, temporary, training, provisional, or limited license obtained in any state in the US or Canadian territory, Canadian province, or US Federal jurisdiction. The issuing authority should mail the verification to the Georgia Composite Medical Board. If licensed by examination, give the state. If licensed by reciprocity, provide the state. Provide the current status of the license: active, inactive, revoked, suspended, probation, limited, etc. You may make copies of this page if more space is needed. Please complete FORM C and forward to the issuing State to request verification be sent "directly" to the Georgia Composite Medical Board.

State/Country	Date Licensed From (mm/dd/yyyy)	Date Licensed To (mm/dd/yyyy)	License Number/Licensed By	Licensure Status

PROGRAM QUESTIONS

	YES	NO
Have you successfully passed the ABC examination in the applied discipline? DATE OF EXAMINATION:_____		
IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO ATTACH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON, AND DISPOSITON OF THE MATTER (INCLUDE COPIES OF COURT ORDERS OR MALPRACTICE SUITS IF APPLICABLE) AND MAIL THIS FORM WITH APPROPRIATE DOCUMENTS DIRECTLY TO THE GEORGIA COMPOSITE MEDICAL BOARD.		
1. Are you a U.S. Citizen? 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.	___	___
2. 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.	___	___
3. 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.	___	___
4. Have you ever been denied the privilege of taking an examination given by any licensing Board or agency?	___	___
5. Has any licensing Board or agency ever denied you a certificate, permit or a license?	___	___
6. Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?	___	___
7. Has any licensing Board or agency ever refused you renewal of a certificate, permit or a license?	___	___
8. Have you ever been denied membership in or in any way sanctioned by any Orthotics and/or Prosthetics association, society, or specialty society?	___	___
9. Have you ever voluntarily surrendered a license, permit or certificate?	___	___
10. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	___	___
11. Do you have any applications for licensure pending before any other licensing Board or agency?	___	___
12. Have you ever been convicted of Medicaid or Medicare fraud, or had any restrictions as a Medicaid or Medicare provider?	___	___
13. Are you in default on a state or federally funded and/or guaranteed school loan?	___	___

APPLICANT WORK HISTORY - Orthotist and Prosthetist

APPLICANTS: If you have an **Associates degree**, you must be able to show you have completed at least five (5) years of work experience in the discipline for which the license is sought, under the supervision of a practitioner licensed or certified in such discipline by an agency accredited by the National Commission for Certifying agencies. If you have a **Baccalaureate degree**, you must document your clinical residency. Please complete your work history only as it relates to the practice of orthotics and/or prosthetics. Please copy this page if additional work history is needed.

CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

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:_____/_____/_____ M DAY YEAR TO: _____/_____/_____ M DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	
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:_____/_____/_____ MM DAY YEAR TO: _____/_____/_____ MM DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	
C. 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:_____/_____/_____ MM DAY YEAR TO: _____/_____/_____ MM DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	

Required Coursework

Instructions: **If you selected associates degree as meeting the transcript requirements, please complete the information below. List the course number and titles from your transcript(s) which satisfy the content area requirements.** **PLEASE SUBMIT A TRANSCRIPT.**

Human Anatomy		
Institution	Course Number and Title	Date Completed (mm/dd/yyyy)

Physiology		
Institution	Course Number and Title	Date Completed (mm/dd/yyyy)

Physics		
Institution	Course Number and Title	Date Completed (mm/dd/yyyy)

Chemistry		
Institution	Course Number and Title	Date Completed (mm/dd/yyyy)

Biology		
Institution	Course Number and Title	Date Completed (mm/dd/yyyy)

EDUCATION INFORMATION

If you obtained a baccalaureate degree from a college or university, provide the name of your training program or college. Indicate all beginning and ending months and years. All gaps in the chronological progression of your training must be explained in the **COMMENTS section below** (i.e., leave of absences, sabbaticals, taking a year off to work in order to pay for the next year of training, etc. If you did not obtain a baccalaureate, enter N/A in the college name field.

NAME OF COLLEGE ATTENDED	**DATES OF ATTENDANCE – MONTH AND YEAR (MM/YY TO MM/YY)**
	1ST YEAR
	2ND YEAR
	3RD YEAR
	4TH YEAR

Comments:_____

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