



Georgia Composite Medical Board Use Only

Temporary #: _____ File Number: _____

Date Issued: _____ License Number: _____

Date Issued: _____

Physician Assistant Application ADD OR CHANGE SUPERVISING PHYSICIAN

All fees are nonrefundable and subject to change.

Temporary approval will be issued to qualified applicants upon completion of the application and will remain in effect until the Board reviews the application. You may not begin work with a new or additional supervising physician without a written notice of temporary approval. **Georgia State Government or Georgia County employees are fee exempt** Federal government employees are not exempt).

NOTE: AN ALTERNATE SUPERVISOR DOES NOT AUTOMATICALLY BECOME YOUR NEW SUPERVISING PHYSICIAN. YOU MUST SUBMIT A NEW APPLICATION WITH YOUR NEW PRIMARY SUPERVISOR.

Physician Assistant 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

License #: _____

Birth Date (mm/dd/yy) / / DEA #: _____

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					



PHYSICIAN ASSISTANT - APPLICANT QUESTIONNAIRE

	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 MEDICAL BOARD.	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 by any State licensing board or been denied a certificate/licensure, or refused renewal of a certificate or license by any licensing board or agency?	—	—
4.	Has any licensing Board or agency ever taken a public or private disciplinary action against you?	—	—
5.	Have you ever had any malpractice suits filed against you?	—	—
6.	Have you ever had your hospital privileges limited, denied or revoked?	—	—
7.	Have you ever resigned from a hospital after a complaint has been initiated against you, or for any other reason?	—	—
8.	Have you ever had any restrictions as a Medicaid or Medicare provider?	—	—
9.	Have you ever voluntarily surrendered your PA certificate/license?	—	—
10.	Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	—	—
11.	Is this application for an additional primary supervising physician?	—	—
12.	Are you resigning for your current supervising physician/position? If yes, complete Form H - Resignation Notification Form and submit with your completed application.	—	—
13.	Are you requesting additional duties? If yes, download Form B – Additional Duties Request Form from our website. Submit this form with your completed application.	—	—
14.	Are you a Georgia state employee? If yes, you are fee exempt . If yes, enter the Facility Name: _____	—	—
15.	Are you a Georgia county employee? If yes, you are fee exempt . If yes, enter the Facility Name: _____	—	—



Utilization of Physician Assistant

Provide physician information for the physician requesting utilization of a physician assistant.

Degree (MD/DO): _____

License Number: _____

First Name: _____

Middle Name: _____

Last Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Specialty: _____

Business Phone: _____

Type of Primary Practice Setting: _____

Telemedicine Practice: Yes _____ No _____

If you checked "yes":

Please provide the physical address in which the PA will be using to provide Telemedicine services.

***If specialty is Pain Management please refer to pain management rules and regulations for additional requirements.