

FORM C
LICENSURE VERIFICATION FORM

This form should be sent to each state where you hold or have held a license/certificate to practice Respiratory Care. This form may be photocopied.

I am applying for certification under the Respiratory Care Practices Act with the Georgia Composite Medical Board. The Georgia Board requires that your Board complete this form in order that I may be considered for certification. By signing this form, I give my consent to release any information, favorable or otherwise, for their review in considering me for a Georgia certificate. As soon as possible, please forward the completed form to the Board at the address listed below.

Section 1 (to be completed by applicant):

My certificate number _____ was issued by your State Board on ____/____/____ on the basis of:

- NBRC Grandparent Provision Graduation from an approved school
 Other _____

Name ***(Please print or type)*** _____

Signature _____

Street Address _____ City, State & Zip Code _____

Section 2 (to be completed by an official of the above referenced Licensing Board):

Respiratory Care Professional Certificate No. _____ to practice as a Respiratory Care Professional in the State of _____ was issued to above-mentioned Respiratory Care Professional on month/____ day/____ year/____.

1. Is certificate in good standing? Yes No Date license expires(d) (mm/yy) ____/____
2. Has any disciplinary action ever been taken against the above Respiratory Care Professional including but not limited to suspension or revocation? Yes No

If yes, please furnish details: _____

Signed _____

Title _____

State Seal

State Board _____

Date _____

Please mail this form to:

**Georgia Composite Medical Board
Respiratory Care Professional Unit
2 Martin Luther King Jr. Drive, SE
East Tower, 11th Floor
Atlanta, GA 30334**

**or submit via email
GCMB.RespiratoryCare@dch.ga.gov**