FORM E
Respiratory Care Professional
CHANGE OF MEDICAL DIRECTOR FORM

I hereby certify that _____, will be employed
Respiratory Care Professional Name

under my supervision as a Health Care Professional in Respiratory Care, effective

_____/_____/_____.

I hold an active license to practice medicine in the State of Georgia. My license

number is _____.

Please type or print: _____
Medical Director/Physician's Name

Signature: _____ Date:_____

Mail completed form to:

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

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